Exhibit A

Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6057(b) and 6058(a) of the Internal Revenue Code (the Code).

▶ Complete all entries in accordance with the instructions to the Form 5500.

OMB Nos. 1210-0110 1210-0089

2021

This Form is Open to Public Inspection

Part I	Annual Report lo	dentification Information							
For caler	dar plan year 2021 or fisc	cal plan year beginning 08/01/2021		and ending 07/31/2022					
A This r	eturn/report is for:	X a multiemployer plan		loyer plan (Filers checking this b					
	participating employer information in accordar					h the form instruction	ns.)		
		a single-employer plan	a DFE (specify)					
B This r	eturn/report is:	the first return/report	the final return/	report					
		an amended return/report	a short plan ye	ar return/report (less than 12 mo	onths))			
C If the	olan is a collectively-barg	ained plan, check here			X				
D Check	box if filing under:	Form 5558	automatic exte	nsion	the	e DFVC program			
		special extension (enter description	n)						
E If this	is a retroactively adopted	plan permitted by SECURE Act section	201, check here)					
Part II	Basic Plan Infor	mation—enter all requested informatio	n						
1a Nam	e of plan	·			1b	Three-digit plan			
ROCHE	STER AREA CONSTRU	CTION AND MATERIALS HEALTH A			4.	number (PN) ▶	501		
					1c	Effective date of pla 01/24/1968	an		
Maili	ng address (include room	er, if for a single-employer plan) , apt., suite no. and street, or P.O. Box) , country, and ZIP or foreign postal code	(if foreign see instru	uctions)	2b	Employer Identifica Number (EIN) 16-0962644	tion		
		CTION AND MATERIALS HEALTH AND			2c	Plan Sponsor's tele number 585-254-1700	ephone		
	TRO PARK STER, NY 14623-2610				2d	Business code (see instructions)	e		
Caution:	Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.								
	Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete.								
SIGN HERE	Filed with authorized/vali	d electronic signature.	12/06/2022	DAVE WEILERT					
			i e						

Date

Date

Date

For Paperwork Reduction Act Notice, see the Instructions for Form 5500.

Signature of plan administrator

Signature of DFE

Signature of employer/plan sponsor

SIGN HERE

SIGN HERE Enter name of individual signing as plan administrator

Enter name of individual signing as DFE

Enter name of individual signing as employer or plan sponsor

Page 2 Form 5500 (2021) **3a** Plan administrator's name and address Same as Plan Sponsor 3b Administrator's EIN 16-0962644 ROCHESTER AREA CONSTRUCTION AND MATERIALS HEALTH AND WELFARE FUND 3c Administrator's telephone number 130 METRO PARK 585-254-1700 **ROCHESTER, NY 14623-2610** If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, 4b EIN enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report: **4d** PN а Sponsor's name Plan Name 5 Total number of participants at the beginning of the plan year 1612 5 6 Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines 6a(1), 6a(2), 6b, 6c, and 6d). 1612 a(1) Total number of active participants at the beginning of the plan year...... 6a(1) 1609 a(2) Total number of active participants at the end of the plan year 6a(2)327 6b Retired or separated participants receiving benefits..... 861 Other retired or separated participants entitled to future benefits 6c 2797 Subtotal. Add lines 6a(2), 6b, and 6c. 6d 10 Deceased participants whose beneficiaries are receiving or are entitled to receive benefits. 6e 2807 Total. Add lines 6d and 6e. 6f Number of participants with account balances as of the end of the plan year (only defined contribution plans 6g complete this item) h Number of participants who terminated employment during the plan year with accrued benefits that were 6h less than 100% vested. 48 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)...... If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions: **b** If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions: 4B 4D 4E 4F Plan funding arrangement (check all that apply) **9b** Plan benefit arrangement (check all that apply) (1)Insurance (1) Insurance (2) Code section 412(e)(3) insurance contracts (2) Code section 412(e)(3) insurance contracts (3)Trust (3) (4) General assets of the sponsor (4) General assets of the sponsor Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions) a Pension Schedules **b** General Schedules X R (Retirement Plan Information) H (Financial Information) (1) (1) I (Financial Information - Small Plan) (2) MB (Multiemployer Defined Benefit Plan and Certain Money (2) X (3) 23 A (Insurance Information) Purchase Plan Actuarial Information) - signed by the plan actuary X (4) C (Service Provider Information) **D** (DFE/Participating Plan Information) (5) (3) SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary (6) G (Financial Transaction Schedules)

Receipt Confirmation Code_

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

File as an attachment to Form 5500.

OMB No. 1210-0110

Employee Benefits Security Ad	iriiriistratiori	, , , , , , ,					
Pension Benefit Guaranty Co	orporation	•	es are required to provide the information to ERISA section 103(a)(2).			m is Open to Public Inspection	
For calendar plan year 20	21 or fiscal pla	n year beginning 08/01/2021		and en	ding 07/3	1/2022	
A Name of plan				B Three	e-digit		
ROCHESTER AREA CO	NSTRUCTION	AND MATERIALS HEALTH A		plan	number (PN	1)	501
				·	,	,	
C Plan sponsor's name a	as shown on lin	e 2a of Form 5500		D Emplo	yer Identific	ation Number	(EIN)
ROCHESTER AREA CO	NSTRUCTION	AND MATERIALS HEALTH AND	WELFARE FUND	16-	0962644		
		rning Insurance Contract L. Individual contracts grouped as					
1 Coverage Information:		<u> </u>					
(a) Name of insurance ca	arrier						
UNITED HEALTH CARE F							
	(a) NIAIC	(4) Continue to an	(e) Approximate nu	mber of		Policy or c	ontract year
(b) EIN	(c) NAIC code	(d) Contract or identification number	persons covered at policy or contract	end of	(f)	From	(g) To
04-0734860	55107	H2001	160		01/01/202	I	12/31/2021
2 Insurance fee and com descending order of the		ation. Enter the total fees and total	al commissions paid. Lis	st in line 3	the agents,	brokers, and c	other persons in
(a) Total	amount of com	missions paid		(b) To	tal amount	of fees paid	
3 Persons receiving com	missions and f	ees. (Complete as many entries	as needed to report all p	persons).			
	(a) Name a	and address of the agent, broker,	or other person to whon	n commiss	ions or fees	were paid	
(b) Amount of sales a	nd base	Fee	s and other commission	ns paid			
commissions pa	iid	(c) Amount	((d) Purpose	9		(e) Organization code
	(a) Name a	and address of the agent, broker,	or other person to whon	n commiss	ions or fees	were paid	
		·					
(b) Amount of sales a	nd base	Fee	s and other commission	ns paid			
commissions pa		(c) Amount	((d) Purpose	9		(e) Organization code

Schedule A (Form 5500) 2	2021	Page 2 – 1						
(a) Na	me and address of the agent, broke	r. or other person to whom commis	sions or fees were paid					
1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1								
		Fees and other commissions paid		(e)				
(b) Amount of sales and base commissions paid	(c) Amount	(d) Po	ırpose	Organization code				
commissions paid		. ,	·	Code				
(a) Na	me and address of the agent, broke	r, or other person to whom commis	sions or fees were paid					
(b) Amount of color and boss		Fees and other commissions paid		(e)				
(b) Amount of sales and base commissions paid	(c) Amount	(d) Pt	urpose	Organization code				
())								
(a) Na	me and address of the agent, broke	r, or other person to whom commis	sions or fees were paid					
		Face and other commissions noid		(0)				
(b) Amount of sales and base		Fees and other commissions paid		(e) Organization				
commissions paid	(c) Amount	(a) Pt	urpose	code				
(a) Na	me and address of the agent, broke	r, or other person to whom commis	sions or fees were paid					
, ,	J ,	,	•					
		Fees and other commissions paid		(e)				
(b) Amount of sales and base commissions paid	(c) Amount	(d) Pt	ırpose	Organization code				
osiminosione paid				3043				
(a) Na	me and address of the agent, broke	r, or other person to whom commis	sions or fees were paid					
	Т			Г				
(b) Amount of sales and base		Fees and other commissions paid		(e) Organization				
commissions paid	(c) Amount	(d) Pt	urpose	code				

Schedule A (Form 5500) 2021

	Part				
		Where individual contracts are provided, the entire group of such individual this report.	idual contracts with each carrier may	be treated	as a unit for purposes of
4	Curr	rrent value of plan's interest under this contract in the general account at year	end	4	
5	Curr	rrent value of plan's interest under this contract in separate accounts at year e	nd	5	
6	Cont	ntracts With Allocated Funds:			
	а	State the basis of premium rates			
	L			CI-	
	b	Premiums paid to carrier		6b	
	Ч С	Premiums due but unpaid at the end of the year		6c	
	d	If the carrier, service, or other organization incurred any specific costs in co retention of the contract or policy, enter amount		6d	
		Specify nature of costs			
	е	Type of contract: (1) individual policies (2) group deferre	d annuity		
		(3) other (specify)			
		(e) [
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, check here		
7		ntracts With Unallocated Funds (Do not include portions of these contracts ma	<u> </u>		
-	а		ate participation guarantee		
	_	(3) guaranteed investment (4) other			
		(o) guarantood invostinont (i) guaranto			
	b	Balance at the end of the previous year		7b	
	С	Additions: (1) Contributions deposited during the year	7c(1)	•	
		(2) Dividends and credits	7c(2)		
		(3) Interest credited during the year	7c(3)		
		(4) Transferred from separate account	7c(4)		
		(5) Other (specify below)	7c(5)		
		•			
				7 - (0)	
	_1	(6)Total additions		7c(6)	
		Total of balance and additions (add lines 7b and 7c(6)) Deductions:		7d	
	C	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
		(2) Administration charge made by carrier	7e(2)		
		(3) Transferred to separate account	7e(3)		
		(4) Other (specify below)	7e(4)		
		•			
		(5) Total deductions		7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)		7f	

	T						
Part III	Welfare Benefit Contract Information more than one contract covers the same the information may be combined for report employees, the entire group of such individual.	group of employees of the	tracts are	expe	rience-rated as a uni	t. Where co	ontracts cover individual
8 Benefit a	and contract type (check all applicable boxes)						
_	ealth (other than dental or vision)	b Dental		cП	Vision		d Life insurance
		블		ш			
. =	emporary disability (accident and sickness)	f Long-term disabil			Supplemental unem	pioyment	h Prescription drug
i∐s	top loss (large deductible)	j HMO contract		k 📙	PPO contract		I Indemnity contract
m 🗌 C	Other (specify)						
9 Experien	ce-rated contracts:						
a Pren	niums: (1) Amount received		9a(1)				
(2)	Increase (decrease) in amount due but unpaid	t	9a(2)				
` '	Increase (decrease) in unearned premium res		9a(3)			1	
	Earned ((1) + (2) - (3))					. 9a(4)	
	nefit charges (1) Claims paid						
` ,	Increase (decrease) in claim reserves					01 (0)	
` ,	Incurred claims (add (1) and (2))					9b(3)	
` '	Claims charged			•••••		9b(4)	
C Re	mainder of premium: (1) Retention charges (c	,	00/4)//				
	(A) Commissions		9c(1)(A 9c(1)(E				
	(B) Administrative service or other fees		9c(1)(C				
	(C) Other specific acquisition costs(D) Other expenses		9c(1)(E				
	(E) Taxes		9c(1)(E				
	(F) Charges for risks or other contingencies .		0.74\/5				
	(G) Other retention charges		- ////				
	(H) Total retention					9c(1)(H)	
(2)	Dividends or retroactive rate refunds. (These	amounts were paid i	n cash, or	cr	redited.)	9c(2)	
	itus of policyholder reserves at end of year: (1	<u></u>				9d(1)	
	Claim reserves					9d(2)	
1.1	Other reserves					9d(3)	
e Div	idends or retroactive rate refunds due. (Do n	ot include amount entere	d in line 90	c (2) .)		9e	
10 Nonex	perience-rated contracts:					•	
a Tot	al premiums or subscription charges paid to o	arrier				10a	1
b If th	ne carrier, service, or other organization incur	red any specific costs in	connection	with	the acquisition or		
	ention of the contract or policy, other than rep	orted in Part I, line 2 abor	ve, report a	amou	ınt	10b	
Specify	nature of costs.						
B	Developer (1.4						
Part IV	Provision of Information				-		
11 Did the	insurance company fail to provide any inform	nation necessary to comp	lete Sched	dule /	Α?	Yes	X No
12 If the a	nswer to line 11 is "Yes," specify the informat	ion not provided.					

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

File as an attachment to Form 5500.

OMB No. 1210-0110

Employed Belletie Gooding 710							
Pension Benefit Guaranty C	orporation		ies are required to provide the information to ERISA section 103(a)(2). This Form is Open to Polynomial Inspection				
For calendar plan year 20	21 or fiscal pla	n year beginning 08/01/2021		and en	ding 07/31	/2022	
A Name of plan ROCHESTER AREA CO	NSTRUCTION	AND MATERIALS HEALTH A		B Three plan	e-digit number (PN) •	501
C Plan sponsor's name a		e 2a of Form 5500 AND MATERIALS HEALTH AN			yer Identifica 0962644	ation Number	(EIN)
		rning Insurance Contrac a. Individual contracts grouped a					
1 Coverage Information:							
(a) Name of insurance ca		(d) Contract or	(e) Approximate nur			Policy or c	ontract year
(b) EIN	code	identification number	persons covered at policy or contract		(f)	From	(g) To
15-0329043	55107	97177-0002	7	your	01/01/2021		12/31/2021
2 Insurance fee and com descending order of the		ation. Enter the total fees and to	tal commissions paid. Lis	t in line 3	the agents, b	orokers, and c	ther persons in
(a) Total	amount of com	missions paid		(b) To	tal amount c	f fees paid	
3 Persons receiving com	missions and f	ees. (Complete as many entries	s as needed to report all p	ersons).			
	(a) Name a	and address of the agent, broker	, or other person to whom	commiss	ions or fees	were paid	
							1
(b) Amount of sales a			es and other commissions				
commissions pa	nid	(c) Amount	(0	d) Purpose	9		(e) Organization code
	(a) Name a	and address of the agent, broker	, or other person to whom	commiss	ions or fees	were paid	
(b) Amount of sales a	nd hase	Fe	es and other commissions	s paid			
commissions pa		(c) Amount	(0	d) Purpose	e		(e) Organization code
							•

Schedule A (Form 5500) 2	2021	Page 2 – 1	
(a) Nar	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
(u) Hai	The and address of the agent, broken	, or other person to whom commissions or rece were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base	(c) Amount	(d) Purpose	Organization
commissions paid	(b) / tillodin	(a) i dipose	code
(a) Nar	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Nar	me and address of the agent, broker.	r, or other person to whom commissions or fees were paid	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Nar	ne and address of the agent, broker	, or other person to whom commissions or fees were paid	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Nar	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
	,		
(1) A		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code

Schedule A (Form 5500) 2021

F	Part				
		Where individual contracts are provided, the entire group of such indivi	dual contracts with	n each carrier may be tre	ated as a unit for purposes of
1	Curr	this report. ent value of plan's interest under this contract in the general account at year.	end	4	
		ent value of plan's interest under this contract in the general accounts at year e			
_		racts With Allocated Funds:			<u>_</u>
Ŭ	a	State the basis of premium rates			
	_	Clate the basic of promisin rates 7			
	b	Premiums paid to carrier		6b	<u> </u>
	С	Premiums due but unpaid at the end of the year		_	
	d	If the carrier, service, or other organization incurred any specific costs in cor	nnection with the a	cquisition or 60	1
		retention of the contract or policy, enter amount			<u>'</u>
		Specify nature of costs			
	е	Type of contract: (1) individual policies (2) group deferred	d annuity		
		(3) other (specify)			
		_			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, check h	nere 🕨 🗌	
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in separat	e accounts)	
	а		te participation gu		
		(3) ☐ guaranteed investment (4) ☐ other ▶			
		(b) [] guaranteed investment (1) [] ether y			
	b	Balance at the end of the previous year			, [
	c	Additions: (1) Contributions deposited during the year	7c(1)		
	_	(2) Dividends and credits	7c(2)		
		(3) Interest credited during the year	7c(3)		
		(4) Transferred from separate account	7c(4)		
		(5) Other (specify below)	7c(5)		
		>			
		(6)Total additions		7c(6)
	d	Total of balance and additions (add lines 7b and 7c(6)).			
	е	Deductions:			
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
		(2) Administration charge made by carrier	7e(2)		
		(3) Transferred to separate account	7e(3)		
		(4) Other (specify below)	7e(4)		
		•			
		(5) Total deductions		7e(5)
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			

	ne same employer(s) or members of the same employee organizations(s), ntracts are experience-rated as a unit. Where contracts cover individual carrier may be treated as a unit for purposes of this report.
8 Benefit and contract type (check all applicable boxes)	_
a X Health (other than dental or vision) b ☐ Dental	c ☐ Vision d ☐ Life insurance
e ☐ Temporary disability (accident and sickness) f ☐ Long-term disabi	lity g Supplemental unemployment h Prescription drug
i Stop loss (large deductible) j HMO contract	k ☐ PPO contract I ☐ Indemnity contract
m ☐ Other (specify) ▶	
9 Experience-rated contracts:	
a Premiums: (1) Amount received	92(1)
(2) Increase (decrease) in amount due but unpaid	9a(1) 9a(2)
(3) Increase (decrease) in unearned premium reserve	
(4) Earned ((1) + (2) - (3))	
b Benefit charges (1) Claims paid	
(2) Increase (decrease) in claim reserves	21 (2)
(3) Incurred claims (add (1) and (2))	
(4) Claims charged	2.70
C Remainder of premium: (1) Retention charges (on an accrual basis)	
(A) Commissions	9c(1)(A)
(B) Administrative service or other fees	9c(1)(B)
(C) Other specific acquisition costs	9c(1)(C)
(D) Other expenses	9c(1)(D)
(E) Taxes	9c(1)(E)
(F) Charges for risks or other contingencies	
(G) Other retention charges	·
(H) Total retention	_
(2) Dividends or retroactive rate refunds. (These amounts were paid	in cash, or credited.)
d Status of policyholder reserves at end of year: (1) Amount held to provide	e benefits after retirement
(2) Claim reserves	9d(2)
(3) Other reserves	9d(3)
e Dividends or retroactive rate refunds due. (Do not include amount entere	ed in line 9c(2).)
10 Nonexperience-rated contracts:	
Total premiums or subscription charges paid to carrier	10a
b If the carrier, service, or other organization incurred any specific costs in retention of the contract or policy, other than reported in Part I, line 2 abo	connection with the acquisition or ove, report amount
Specify nature of costs. Port IV Provision of Information	
Part IV Provision of Information	
11 Did the insurance company fail to provide any information necessary to com	plete Schedule A? Yes X No
12 If the answer to line 11 is "Yes," specify the information not provided.	

Department of the Treasury Internal Revenue Service

Department of Labor

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

File as an attachment to Form 5500.

OMB No. 1210-0110

Employee Benefits Security Ad	ministration	File as all a	ttacililent to Form 55	00.			
Pension Benefit Guaranty Corporation Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).			This I	Form is Open to Public Inspection			
For calendar plan year 20.	21 or fiscal pla	n year beginning 08/01/2021		and en	ding 07/3	1/2022	
A Name of plan ROCHESTER AREA CO	NSTRUCTION	AND MATERIALS HEALTH A			e-digit number (PN	1)	501
C Plan sponsor's name a		e 2a of Form 5500 AND MATERIALS HEALTH AND	WELFARE FUND		yer Identifica 0962644	ation Numb	er (EIN)
		rning Insurance Contract Lindividual contracts grouped as					
1 Coverage Information:							
(a) Name of insurance ca	N T	T	(e) Approximate nu	umber of		Policy o	or contract year
(b) EIN	(c) NAIC code	(d) Contract or identification number	persons covered at policy or contract	t end of	(f)	From	(g) To
15-0329043	55107	313146-0001	1		01/01/2021	1	12/31/2021
2 Insurance fee and com descending order of the		ation. Enter the total fees and tota	al commissions paid. Li	st in line 3	the agents, I	brokers, an	d other persons in
(a) Total a	amount of com	missions paid		(b) To	otal amount of	of fees paid	1
3 Persons receiving com	missions and f	ees. (Complete as many entries a	as needed to report all	persons).			
-	(a) Name a	and address of the agent, broker,	or other person to whor	n commiss	ions or fees	were paid	
		Foo	s and other commissior	os paid			
(b) Amount of sales ar commissions pa		(c) Amount		(d) Purpos	•		(e) Organization code
commissions pa	lu	(C) Amount		(u) 1 u1pos	3		(e) Organization code
	(a) Name a	and address of the agent, broker,	or other person to whor	n commiss	ions or fees	were paid	
	,,		,			1 2	
(b) Amount of sales ar	nd hase	Fee	s and other commission	ns paid			
commissions pa		(c) Amount		(d) Purpose	е		(e) Organization code
For Parameter Park C	n Ant Note:	and the Instructions for Form F	500				hodulo A /Form F500) 2021

Schedule A (Form 5500) 2	2021	Page 2 – 1	
(a) Na	me and address of the agent, bro	oker, or other person to whom commissions or fees were paid	
	Г		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	me and address of the agent, bro	oker, or other person to whom commissions or fees were paid	
	T		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	me and address of the agent, bro	oker, or other person to whom commissions or fees were paid	
	ı		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	me and address of the agent, bro	oker, or other person to whom commissions or fees were paid	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	me and address of the agent, bro	oker, or other person to whom commissions or fees were paid	
	-		
			I
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
	l	1	I

Schedule A (Form 5500) 2021

	Part				
		Where individual contracts are provided, the entire group of such individual this report.	idual contracts with each carrier may	be treated	as a unit for purposes of
4	Curr	rrent value of plan's interest under this contract in the general account at year	end	4	
5	Curr	rrent value of plan's interest under this contract in separate accounts at year e	nd	5	
6	Cont	ntracts With Allocated Funds:			
	а	State the basis of premium rates			
	L			CI-	
	b	Premiums paid to carrier		6b	
	Ч С	Premiums due but unpaid at the end of the year		6c	
	d	If the carrier, service, or other organization incurred any specific costs in co retention of the contract or policy, enter amount		6d	
		Specify nature of costs			
	е	Type of contract: (1) individual policies (2) group deferre	d annuity		
		(3) other (specify)			
		(e) [
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, check here		
7		ntracts With Unallocated Funds (Do not include portions of these contracts ma	<u> </u>		
-	а		ate participation guarantee		
	_	(3) guaranteed investment (4) other			
		(o) guarantood invostinont (i) guaranto			
	b	Balance at the end of the previous year		7b	
	С	Additions: (1) Contributions deposited during the year	7c(1)	•	
		(2) Dividends and credits	7c(2)		
		(3) Interest credited during the year	7c(3)		
		(4) Transferred from separate account	7c(4)		
		(5) Other (specify below)	7c(5)		
		•			
				7 - (0)	
	_1	(6)Total additions		7c(6)	
		Total of balance and additions (add lines 7b and 7c(6)) Deductions:		7d	
	C	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
		(2) Administration charge made by carrier	7e(2)		
		(3) Transferred to separate account	7e(3)		
		(4) Other (specify below)	7e(4)		
		•			
		(5) Total deductions		7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)		7f	

Part III Welfare Benefit Contract Information If more than one contract covers the same group of employees of the information may be combined for reporting purposes if such or	the same employer(s) or members of the same employee organizations(s), ontracts are experience-rated as a unit. Where contracts cover individual
employees, the entire group of such individual contracts with each	
Benefit and contract type (check all applicable boxes)	
a ☐ Health (other than dental or vision) b ☐ Dental	c ☐ Vision d ☐ Life insurance
e ☐ Temporary disability (accident and sickness) f ☐ Long-term disa	bility g Supplemental unemployment h Prescription drug
i Stop loss (large deductible) j HMO contract	k ☐ PPO contract I ☐ Indemnity contract
m Other (specify)	_
9 Experience-rated contracts:	
a Premiums: (1) Amount received	9a(1)
(2) Increase (decrease) in amount due but unpaid	
(3) Increase (decrease) in unearned premium reserve	9a(3)
(4) Earned ((1) + (2) - (3))	9a(4)
b Benefit charges (1) Claims paid	·
(2) Increase (decrease) in claim reserves	9b(2)
(3) Incurred claims (add (1) and (2))	
(4) Claims charged	
C Remainder of premium: (1) Retention charges (on an accrual basis)	
(A) Commissions	9c(1)(A)
(B) Administrative service or other fees	
(C) Other specific acquisition costs	
(D) Other expenses	0.4440
(E) Taxes	0-(4)(5)
(F) Charges for risks or other contingencies	0 (4)(=)
(G) Other retention charges	0.747/07
(H) Total retention	0.4040
(2) Dividends or retroactive rate refunds. (These amounts were paid	
<u> </u>	
d Status of policyholder reserves at end of year: (1) Amount held to provi	
(2) Claim reserves	
(3) Other reserves	
Dividends or retroactive rate refunds due. (Do not include amount enter	red in line 9c(2).) 9e
10 Nonexperience-rated contracts:	40-
Total premiums or subscription charges paid to carrier	
b If the carrier, service, or other organization incurred any specific costs i	
retention of the contract or policy, other than reported in Part I, line 2 at Specify nature of costs.	pove, report amount
Specify flature of costs.	
Part IV Provision of Information	
11 Did the insurance company fail to provide any information necessary to con	nplete Schedule A? Yes X No
12 If the answer to line 11 is "Yes," specify the information not provided.	

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

File as an attachment to Form 5500.

OMB No. 1210-0110

Employee Benefits Security Ad	iriiriistratiori	, , , , , , ,				
Pension Benefit Guaranty Corporation Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).			This For	m is Open to Public Inspection		
For calendar plan year 20	21 or fiscal pla	n year beginning 08/01/2021		and ending 07/3	31/2022	
A Name of plan			В	Three-digit		
ROCHESTER AREA CO	NSTRUCTION	AND MATERIALS HEALTH A		plan number (P	N) •	501
				·	,	
C Plan sponsor's name a	as shown on lin	e 2a of Form 5500	D	Employer Identific	cation Number	(EIN)
ROCHESTER AREA CO	NSTRUCTION	AND MATERIALS HEALTH AND	WELFARE FUND	16-0962644		
		rning Insurance Contract a. Individual contracts grouped as				
1 Coverage Information:		Ţ,		•	Ü	
(a) Name of insurance ca	arrier					
EXCELLUS HEALTH PLA						
	(-) 11416	(1) 0	(e) Approximate numb	per of	Policy or co	ontract year
(b) EIN	(c) NAIC code	(d) Contract or identification number	persons covered at er policy or contract ye	nd of	From	(g) To
15-0329043	55107	964369-0001	9	01/01/202	21	12/31/2021
2 Insurance fee and com descending order of the		ation. Enter the total fees and total	al commissions paid. List i	n line 3 the agents,	brokers, and o	ther persons in
(a) Total amount of commissions paid (b) Total amount of fees paid						
3 Persons receiving com		ees. (Complete as many entries				
	(a) Name a	and address of the agent, broker,	or other person to whom c	ommissions or fees	s were paid	
(b) Amount of sales a	nd base	Fee	s and other commissions p	paid		
commissions pa	id	(c) Amount	(d)	Purpose		(e) Organization code
	(a) Name a	and address of the agent, broker,	or other person to whom c	ommissions or fees	s were paid	
	(-,/					
(b) Amount of sales a	nd base	Fee	s and other commissions p	oaid		
commissions pa		(c) Amount	(d)	Purpose		(e) Organization code

Schedule A (Form 5500) 2	2021	Page 2 – 1	
(a) Nar	ne and address of the agent, broker	r, or other person to whom commissions or fees were paid	
(-)		,	
		Fees and other commissions paid	(e)
(b) Amount of sales and base	(c) Amount	(d) Purpose	Organization
commissions paid	(c) Amount	(a) i dipose	code
(a) Nar	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Nar	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
commissions paid			code
(a) Nar	ne and address of the agent, broker	, or other person to whom commissions or fees were paid	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Nar	ne and address of the agent, broker	, or other person to whom commissions or fees were paid	
· · ·			
(I-X Assessment of a little		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code

Schedule A (Form 5500) 2021

	Part		idual contracto with cook corrier mou	ha traataa	log a unit for nurnage of
		Where individual contracts are provided, the entire group of such individual this report.	idual contracts with each camer may	De liealec	i as a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end	4	
5	Curr	ent value of plan's interest under this contract in separate accounts at year e	nd	5	
6	Con	tracts With Allocated Funds:			
	а	State the basis of premium rates			
			1		
	b	Premiums paid to carrier		6b	
	C	Premiums due but unpaid at the end of the year		6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount	•	6d	
		Specify nature of costs			
		oposity flature of society			
	е	Type of contract: (1) individual policies (2) group deferred	d annuity		
			a armany		
		(3) other (specify)			
_	<u> </u>	If contract purchased, in whole or in part, to distribute benefits from a termin	<u> </u>		
1		tracts With Unallocated Funds (Do not include portions of these contracts ma			
	а		ate participation guarantee		
		(3) guaranteed investment (4) other			
	b	Balance at the end of the previous year		7b	
	С	Additions: (1) Contributions deposited during the year	7c(1)		
		(2) Dividends and credits	7c(2)		
		(3) Interest credited during the year	7c(3)		
		(4) Transferred from separate account	7c(4) 7c(5)		
		(5) Other (specify below)	70(3)		
		•			
				7 - (0)	
		(6)Total additions		7c(6)	
		Total of balance and additions (add lines 7b and 7c(6))		7d	
	E	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
		(2) Administration charge made by carrier	7e(2)		
		(3) Transferred to separate account	7e(3)		
		(4) Other (specify below)	7e(4)		
		•	- (- /		
		,			
		(E) Total de destace		70/F)	
	£	(5) Total deductions	ı	7e(5) 7f	
	I	Balance at the end of the current year (subtract line 7e(5) from line 7d)		11	

Part III Welfare Benefit Contract Information If more than one contract covers the same group of employees of the information may be combined for reporting purposes if such or	the same employer(s) or members of the same employee organizations(s), ontracts are experience-rated as a unit. Where contracts cover individual
employees, the entire group of such individual contracts with each	
Benefit and contract type (check all applicable boxes)	
a ☐ Health (other than dental or vision) b ☐ Dental	c ☐ Vision d ☐ Life insurance
e ☐ Temporary disability (accident and sickness) f ☐ Long-term disa	bility g Supplemental unemployment h Prescription drug
i Stop loss (large deductible) j HMO contract	k ☐ PPO contract I ☐ Indemnity contract
m Other (specify)	_
9 Experience-rated contracts:	
a Premiums: (1) Amount received	9a(1)
(2) Increase (decrease) in amount due but unpaid	
(3) Increase (decrease) in unearned premium reserve	9a(3)
(4) Earned ((1) + (2) - (3))	9a(4)
b Benefit charges (1) Claims paid	·
(2) Increase (decrease) in claim reserves	9b(2)
(3) Incurred claims (add (1) and (2))	
(4) Claims charged	
C Remainder of premium: (1) Retention charges (on an accrual basis)	
(A) Commissions	9c(1)(A)
(B) Administrative service or other fees	
(C) Other specific acquisition costs	
(D) Other expenses	0.4440
(E) Taxes	0-(4)(5)
(F) Charges for risks or other contingencies	0 (4)(=)
(G) Other retention charges	0.747/07
(H) Total retention	0.4040
(2) Dividends or retroactive rate refunds. (These amounts were paid	
<u> </u>	
d Status of policyholder reserves at end of year: (1) Amount held to provi	
(2) Claim reserves	
(3) Other reserves	
Dividends or retroactive rate refunds due. (Do not include amount enter	red in line 9c(2).) 9e
10 Nonexperience-rated contracts:	40-
Total premiums or subscription charges paid to carrier	
b If the carrier, service, or other organization incurred any specific costs i	
retention of the contract or policy, other than reported in Part I, line 2 at Specify nature of costs.	pove, report amount
Specify flature of costs.	
Part IV Provision of Information	
11 Did the insurance company fail to provide any information necessary to con	nplete Schedule A? Yes X No
12 If the answer to line 11 is "Yes," specify the information not provided.	

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

File as an attachment to Form 5500.

OMB No. 1210-0110

Employee Benefits Security Ad	IIIIIIIStration	, 1110 40 411 4				
Pension Benefit Guaranty Corporation Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).			This For	m is Open to Public Inspection		
For calendar plan year 20	21 or fiscal pla	n year beginning 08/01/2021		and ending 07/3	1/2022	
A Name of plan			В	Three-digit		
ROCHESTER AREA CO	NSTRUCTION	AND MATERIALS HEALTH A		plan number (PI	v)	501
				1 3 3 4	,	
C Plan sponsor's name a	as shown on lin	e 2a of Form 5500	D	Employer Identific	ation Number	(EIN)
·		AND MATERIALS HEALTH AND		16-0962644		,
		rning Insurance Contract L. Individual contracts grouped as				
1 Coverage Information:		<u> </u>		•		
(a) Name of insurance ca	arrier					
MVP HEALTHCARE						
	(-) NIAIO	(4) Control of	(e) Approximate number	er of	Policy or co	ontract year
(b) EIN	(c) NAIC code	(d) Contract or identification number	persons covered at end policy or contract year	d of	From	(g) To
14-1648068	95521	706308-0002	7	01/01/202	1	12/31/2021
2 Insurance fee and com descending order of the		ation. Enter the total fees and total	al commissions paid. List in	line 3 the agents,	brokers, and o	ther persons in
(a) Total amount of commissions paid (b) Total amount of fees paid						
3 Persons receiving com		ees. (Complete as many entries				
	(a) Name a	and address of the agent, broker,	or otner person to wnom co	mmissions or fees	were paid	
(b) Amount of sales a	nd base	Fee	s and other commissions pa	aid		
commissions pa	id	(c) Amount	(d) F	Purpose		(e) Organization code
	(a) Name a	and address of the agent, broker,	or other person to whom co	mmissions or fees	were paid	
	· / ·	U ,	,		1 ***	
(b) Amount of sales a	nd base	Fee	s and other commissions pa	aid		
commissions pa		(c) Amount	(d) F	Purpose		(e) Organization code

Schedule A (Form 5500) 2	2021	Page 2 – 1	
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid	
(d) iva	me and address of the agont, broke	st, or dates percent to whem commissions or received para	
		Fees and other commissions paid	(e)
(b) Amount of sales and base	(c) Amount	(d) Purpose	Organization
commissions paid	(c) Amount	(u) i uipose	code
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base	(a) Amount		Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Nai	me and address of the agent, broke	er, or other person to whom commissions or fees were paid	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid	
χω,	a.a aaa soo oo ago, 2.o	., c. c po to co c. 1000 He.e pana	
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
	1	1	

Schedule A (Form 5500) 2021

	art	Investment and Annuity Contract Information			
		Where individual contracts are provided, the entire group of such individual this report.	lual contracts with each carrier may	be treated	d as a unit for purposes of
4	Curr	rent value of plan's interest under this contract in the general account at year e	nd	4	
		rent value of plan's interest under this contract in separate accounts at year en		5	
_		tracts With Allocated Funds:			
	а	State the basis of premium rates •			
				,	
	b	Premiums paid to carrier		6b	
	C _.	Premiums due but unpaid at the end of the year		6c	
	d	If the carrier, service, or other organization incurred any specific costs in conretention of the contract or policy, enter amount.	·	6d	
		Specify nature of costs			
	е	Type of contract: (1) individual policies (2) group deferred	annuity		
		(3) other (specify)			
	f	If contract purchased, in whole or in part, to distribute benefits from a terminal	iting plan, check here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts main	ntained in separate accounts)		
	а	Type of contract: (1) deposit administration (2) immediate	e participation guarantee		
		(3) ☐ guaranteed investment (4) ☐ other ▶			
		_			
	b	Balance at the end of the previous year		7b	
	С	Additions: (1) Contributions deposited during the year	7c(1)		
		(2) Dividends and credits	7c(2)		
		(3) Interest credited during the year	7c(3)		
		(4) Transferred from separate account	7c(4) 7c(5)		
		(5) Other (specify below)	70(3)		
		(0)7 - 1 - 1/2		7o(6)	
	ч	(6)Total additions	Ī	7c(6) 7d	
		Deductions:		74	
	·	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
		(2) Administration charge made by carrier	7e(2)		
		(3) Transferred to separate account	7e(3)		
		(4) Other (specify below)	7e(4)		
		•			
		(5) Total deductions		7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)	•	7f	

the information may be combined for reporting purposes if such con employees, the entire group of such individual contracts with each of	ne same employer(s) or members of the same employee organizations(s), itracts are experience-rated as a unit. Where contracts cover individual carrier may be treated as a unit for purposes of this report.
8 Benefit and contract type (check all applicable boxes)	
a X Health (other than dental or vision) b ☐ Dental	c
e ☐ Temporary disability (accident and sickness) f ☐ Long-term disabil	lity g Supplemental unemployment h Prescription drug
i Stop loss (large deductible) j HMO contract	k ☐ PPO contract I ☐ Indemnity contract
m ☐ Other (specify) ▶	
9 Experience-rated contracts:	
a Premiums: (1) Amount received	92(1)
(2) Increase (decrease) in amount due but unpaid	9a(1) 9a(2)
(3) Increase (decrease) in unearned premium reserve	
(4) Earned ((1) + (2) - (3))	
b Benefit charges (1) Claims paid	
(2) Increase (decrease) in claim reserves	21 (2)
(3) Incurred claims (add (1) and (2))	
(4) Claims charged	21.70
C Remainder of premium: (1) Retention charges (on an accrual basis)	
(A) Commissions	9c(1)(A)
(B) Administrative service or other fees	9c(1)(B)
(C) Other specific acquisition costs	9c(1)(C)
(D) Other expenses	9c(1)(D)
(E) Taxes	9c(1)(E)
(F) Charges for risks or other contingencies	9c(1)(F)
(G) Other retention charges	9c(1)(G)
(H) Total retention	9c(1)(H)
(2) Dividends or retroactive rate refunds. (These amounts were paid i	in cash, or credited.)
d Status of policyholder reserves at end of year: (1) Amount held to provide	e benefits after retirement
(2) Claim reserves	9d(2)
(3) Other reserves	9d(3)
e Dividends or retroactive rate refunds due. (Do not include amount entere	ed in line 9c(2) .) 9e
10 Nonexperience-rated contracts:	
a Total premiums or subscription charges paid to carrier	10a
b If the carrier, service, or other organization incurred any specific costs in retention of the contract or policy, other than reported in Part I, line 2 about	connection with the acquisition or ve, report amount
Specify nature of costs.	
Part IV Provision of Information	
11 Did the insurance company fail to provide any information necessary to comp	olete Schedule A? Yes X No
12 If the answer to line 11 is "Yes," specify the information not provided.	

Department of the Treasury Internal Revenue Service

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

OMB No. 1210-0110

Department of Labo Employee Benefits Security Ac		File as an a	attachment to Form 55	00.			
Pension Benefit Guaranty Corporation Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).			This For	m is Open to Public Inspection			
For calendar plan year 20	21 or fiscal pla	n year beginning 08/01/2021		and en	ding 07/3	1/2022	
A Name of plan				B Three	e-digit		
ROCHESTER AREA CO	NSTRUCTION	AND MATERIALS HEALTH A		plan	number (PN	N) •	501
C Plan sponsor's name a	as shown on lin	e 2a of Form 5500		D Emplo	yer Identific	ation Number	(EIN)
ROCHESTER AREA CO	NSTRUCTION	AND MATERIALS HEALTH AN	D WELFARE FUND	16-	0962644		
		rning Insurance Contract Lindividual contracts grouped a					
1 Coverage Information:							
(a) Name of insurance ca	arrier						
EXCELLUS BLUE CROSS		o o					
	T		(e) Approximate no	ımber of		Policy or c	ontract year
(b) EIN	(c) NAIC code	(d) Contract or identification number	persons covered a	it end of	(f)	From	(g) To
15-0329043	55107	89829	308	•	01/01/202	1	12/31/2021
2 Insurance fee and com descending order of the		ation. Enter the total fees and tot	tal commissions paid. L	ist in line 3	the agents,	brokers, and o	ther persons in
- U	amount of com	missions paid		(b) To	ntal amount	of fees paid	
(u) rotar	amount or com	missions paid		(5)	nai amount	or roco para	11021
3 Persons receiving com	missions and f	ees. (Complete as many entries	as needed to report all	nersons)			
• 1 crooms receiving con		and address of the agent, broker,			ions or fees	were paid	
LOUIS ARGIRO			ARLINGTON ROAD CUSE, NY 13208			·	
(b) Amount of sales a	nd hoop	Fee	es and other commissio	ns paid			
commissions pa		(c) Amount		(d) Purpose			(e) Organization code
		11021					3
	(a) Name a	and address of the agent, broker,	or other person to who	m commiss	ions or fees	were paid	
	(a) · iaiii e	agan, 2	, 6. 66, person, 106			nore pana	
(b) Amount of sales a	nd base	Fee	es and other commissio	ns paid			
commissions pa		(c) Amount		(d) Purpose			(e) Organization code
For Panerwork Reduction	on Act Notice	see the Instructions for Form	5500.			School	dule A (Form 5500) 2021

Schedule A (Form 5500) 2	2021	Page 2 – 1]		
(a) Na	me and address of the agent, broker	or other person to whom commis	ssions or fees were paid		
χ-,		,			
		Fees and other commissions paid		(e)	
(b) Amount of sales and base	(c) Amount		Purpose	Organization	
commissions paid	(c) Amount	(u) 1	uiposo	code	
(a) Nai	me and address of the agent, broker	, or other person to whom commis	ssions or fees were paid		
				·	
(b) Amount of sales and base		Fees and other commissions paid		(e) Organization	
commissions paid	(c) Amount	(d) F	'urpose	code	
(a) Nai	me and address of the agent, broker	, or other person to whom commis	ssions or fees were paid		
		Fees and other commissions paid	1	(e)	
(b) Amount of sales and base	(c) Amount		Purpose	Organization	
commissions paid	(e) Amount	(3)	шрозс	code	
(a) Na	me and address of the agent, broker	or other person to whom commis	ssions or fees were paid		
, , ,					
(h) Amount of color and have		Fees and other commissions paid		(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(d) F	urpose	Organization code	
(a) Nai	me and address of the agent, broker	, or other person to whom commis	ssions or fees were paid		
,,,					
		Fees and other commissions paid		(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(d) F	Purpose	Organization code	
	ĺ	İ		I	

Schedule A (Form 5500) 2021

	Part				
		Where individual contracts are provided, the entire group of such individual this report.	idual contracts with each carrier may	be treated	as a unit for purposes of
4	Curr	rrent value of plan's interest under this contract in the general account at year	end	4	
5	Curr	rrent value of plan's interest under this contract in separate accounts at year e	nd	5	
6	Cont	ntracts With Allocated Funds:			
	а	State the basis of premium rates			
	L			CI-	
	b	Premiums paid to carrier		6b	
	Ч С	Premiums due but unpaid at the end of the year		6c	
	d	If the carrier, service, or other organization incurred any specific costs in co retention of the contract or policy, enter amount		6d	
		Specify nature of costs			
	е	Type of contract: (1) individual policies (2) group deferre	d annuity		
		(3) other (specify)			
		(e) [
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, check here		
7		ntracts With Unallocated Funds (Do not include portions of these contracts ma	<u> </u>		
-	а		ate participation guarantee		
	_	(3) guaranteed investment (4) other			
		(o) guarantood invostinont (i) guaranto			
	b	Balance at the end of the previous year		7b	
	С	Additions: (1) Contributions deposited during the year	7c(1)	•	
		(2) Dividends and credits	7c(2)		
		(3) Interest credited during the year	7c(3)		
		(4) Transferred from separate account	7c(4)		
		(5) Other (specify below)	7c(5)		
		•			
				7 - (0)	
	_1	(6)Total additions		7c(6)	
		Total of balance and additions (add lines 7b and 7c(6)) Deductions:		7d	
	C	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
		(2) Administration charge made by carrier	7e(2)		
		(3) Transferred to separate account	7e(3)		
		(4) Other (specify below)	7e(4)		
		•			
		(5) Total deductions		7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)		7f	

Part III Welfare Benefit Contract Information If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.						
8 Benefit and contract type (check all applicable boxes)		_		_		
a ☐ Health (other than dental or vision) b ☐ Dental	С	Vision	d	Life insurance		
e ☐ Temporary disability (accident and sickness) f ☐ Long-term disabil	ity g	Supplemental unemp	oloyment h	Prescription drug		
i ☐ Stop loss (large deductible) j ☐ HMO contract	k 🗆	PPO contract	I	Indemnity contract		
m ☐ Other (specify) ▶	_			. ,		
9 Experience-rated contracts:						
a Premiums: (1) Amount received	9a(1)		286060			
(2) Increase (decrease) in amount due but unpaid	9a(2)		200000			
(3) Increase (decrease) in unearned premium reserve						
(4) Earned ((1) + (2) - (3))			9a(4)	286060		
b Benefit charges (1) Claims paid	9b(1)		216843			
(2) Increase (decrease) in claim reserves	9b(2)					
(3) Incurred claims (add (1) and (2))			9b(3)	216843		
(4) Claims charged			9b(4)			
C Remainder of premium: (1) Retention charges (on an accrual basis)						
(A) Commissions	9c(1)(A)		26146			
(B) Administrative service or other fees	9c(1)(B)		32033			
(C) Other specific acquisition costs	9c(1)(C)					
(D) Other expenses	9c(1)(D)					
(E) Taxes	9c(1)(E)					
(F) Charges for risks or other contingencies	9c(1)(F)					
(G) Other retention charges	9c(1)(G)		2 (4)(1)	50470		
(H) Total retention			9c(1)(H)	58179		
(2) Dividends or retroactive rate refunds. (These amounts were paid in			9c(2)			
d Status of policyholder reserves at end of year: (1) Amount held to provide			9d(1)			
(2) Claim reserves	9d(2)					
(3) Other reserves			9d(3)			
e Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).)						
10 Nonexperience-rated contracts:		i				
Total premiums or subscription charges paid to carrier			10a			
b If the carrier, service, or other organization incurred any specific costs in c retention of the contract or policy, other than reported in Part I, line 2 abov Specify nature of costs.	connection wit ve, report amo	h the acquisition or ount	10b			
Part IV Provision of Information						
11 Did the insurance company fail to provide any information necessary to comp	lete Schedule	A?	Yes X	No		
12 If the answer to line 11 is "Yes," specify the information not provided.		<u> </u>				

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

File as an attachment to Form 5500.

OMB No. 1210-0110

Employee Benefits Security Ad	IIIIIIStration	, ino ao an a						
Pension Benefit Guaranty Corporation Insurance companies are required to provide the infugure pursuant to ERISA section 103(a)(2).				on	This Fo	m is Open to Public Inspection		
For calendar plan year 20	21 or fiscal pla	n year beginning 08/01/2021		and en	ding 07/3	1/2022		
A Name of plan				B Three	e-digit			
ROCHESTER AREA CO	NSTRUCTION	AND MATERIALS HEALTH A			number (PN	1) 🕨	501	
				•	,	,		
C Plan sponsor's name a	as shown on lin	e 2a of Form 5500		D Emplo	ver Identifica	ation Number	(EIN)	
ROCHESTER AREA CONSTRUCTION AND MATERIALS HEALTH AND WELFARE FUND 16-0962644						,		
	Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.							
1 Coverage Information:		•						
(a) Name of insurance ca	arrier							
DAVIS VISION								
	(0) NIAIC	(4) 00 - 1 1	(e) Approximate nu	mber of		Policy or c	ontract year	
(b) EIN	(c) NAIC code	(d) Contract or identification number	persons covered at policy or contract	end of	(f)	From	(g) To	
25-1800302	55107	503215	1299		01/01/2021	1	12/31/2021	
2 Insurance fee and com descending order of the		ation. Enter the total fees and total	al commissions paid. Lis	st in line 3	the agents, l	brokers, and c	other persons in	
(a) Total amount of commissions paid (b) Total amount of fees paid								
3 Persons receiving com	missions and f	ees. (Complete as many entries	as needed to report all p	persons).				
	(a) Name a	and address of the agent, broker,	or other person to whon	n commissi	ons or fees	were paid		
(b) Amount of sales a	nd base	Fee	es and other commission	ıs paid				
commissions pa	iid	(c) Amount	(d) Purpose)		(e) Organization code	
	(a) Name a	and address of the agent, broker,	or other person to whon	n commissi	ons or fees	were paid		
	, ,		·					
(b) Amount of sales a	nd base	Fee	es and other commission	s paid				
commissions pa		(c) Amount	(d) Purpose)		(e) Organization code	
	A (N) ((= =====)	

Schedule A (Form 5500) 2021 Page 2 – 1				
(a) Nai	me and address of the agent, broke	er, or other person to whom commissions or fees were paid		
	T			
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code	
(a) Nai	me and address of the agent, broke	er, or other person to whom commissions or fees were paid		
	T			
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code	
(a) Nai	me and address of the agent, broke	er, or other person to whom commissions or fees were paid		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code	
(a) Nai	me and address of the agent, broke	er, or other person to whom commissions or fees were paid		
			ı	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code	
(a) Nai	me and address of the agent, broke	er, or other person to whom commissions or fees were paid		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code	

Schedule A (Form 5500) 2021

Part II Investment and Annuity Contract Information								
		Where individual contracts are provided, the entire group of such indivi	dual contracts wit	h each carrier may	be treated	I as a unit for purposes of		
1	Curr	this report. ent value of plan's interest under this contract in the general account at year of the plan's interest under this contract in the general account at year of the plants are the plants.		4				
				5				
_		rent value of plan's interest under this contract in separate accounts at year end						
Ŭ	a	State the basis of premium rates						
	_	clate the basic of profitant rates 7						
	b	Premiums paid to carrier		Г	6b			
	С	Premiums due but unpaid at the end of the year		F	6c			
	d	If the carrier, service, or other organization incurred any specific costs in cor	nnection with the a	acquisition or	6d			
		retention of the contract or policy, enter amount			ou			
		Specify nature of costs						
	е	Type of contract: (1) individual policies (2) group deferred	d annuity					
		(3) other (specify)						
		_						
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, check	here •				
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in separa	ite accounts)				
	а	`	te participation gu					
		(3) ☐ guaranteed investment (4) ☐ other ▶						
		(b) [] guaranteed investment (1) [] exist y						
	b	Balance at the end of the previous year		Г	7b			
	C	Additions: (1) Contributions deposited during the year	7c(1)		10			
	_	(2) Dividends and credits	7c(2)					
		(3) Interest credited during the year	7c(3)					
		(4) Transferred from separate account	7c(4)					
		(5) Other (specify below)	7c(5)					
		•						
		(6)Total additions			7c(6)			
	ď	Total of balance and additions (add lines 7b and 7c(6))			7d			
	е	Deductions:						
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)					
		(2) Administration charge made by carrier	7e(2)					
		(3) Transferred to separate account	7e(3)					
		(4) Other (specify below)	7e(4)					
		•						
		(5) Total deductions			7e(5)			
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7f			

M. K. D. C. O. 4 4.1							
Part III Welfare Benefit Contract Information If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual							
employees, the entire group of such							
1, 7, 1		same may be neared as a un					
 Benefit and contract type (check all applicable t Health (other than dental or vision) 	b Dental	C X Vision	d∏∟	ife insurance			
e Temporary disability (accident and sicknown)	블	=	브	Prescription drug			
		k ☐ PPO contract	<u>=</u>				
i Stop loss (large deductible)	j	K ☐ PPO contract	"∐ "	ndemnity contract			
m ☐ Other (specify)							
9 Experience-rated contracts:							
a Premiums: (1) Amount received		9a(1)					
(2) Increase (decrease) in amount due but							
(3) Increase (decrease) in unearned premi		- :: 					
, , , , , , , , , , , , , , , , , , , ,			92(4)				
(4) Earned ((1) + (2) - (3))			9a(4)				
b Benefit charges (1) Claims paid							
(2) Increase (decrease) in claim reserves			05/2)				
(3) Incurred claims (add (1) and (2))							
(4) Claims charged			9b(4)				
C Remainder of premium: (1) Retention char	• '						
(A) Commissions		9c(1)(A)					
(B) Administrative service or other fees		9c(1)(B)					
(C) Other specific acquisition costs		9c(1)(C)					
(D) Other expenses		9c(1)(D)					
(E) Taxes		L					
(F) Charges for risks or other continge	ncies						
(G) Other retention charges		9c(1)(G)					
(H) Total retention	<u></u>		9c(1)(H)				
(2) Dividends or retroactive rate refunds.	These amounts were paid	in cash, or credited.)	9c(2)				
d Status of policyholder reserves at end of y	e benefits after retirement	9d(1)					
(2) Claim reserves			9d(2)				
(3) Other reserves			9d(3)				
e Dividends or retroactive rate refunds due.	(Do not include amount entere	ed in line 9c(2) .)	9e				
10 Nonexperience-rated contracts:							
a Total premiums or subscription charges pa	nid to carrier		10a				
b If the carrier, service, or other organization	incurred any specific costs in	connection with the acquisition	n or				
retention of the contract or policy, other that							
Specify nature of costs.	•	•	<u> </u>				
Part IV Provision of Information							
			□ Vaa □ N				
11 Did the insurance company fail to provide any information necessary to complete Schedule A?							
12 If the answer to line 11 is "Yes," specify the in	ormation not provided.						

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

File as an attachment to Form 5500.

OMB No. 1210-0110

Employee Benefits Security Administration / The de dar database security Administration							
Pension Benefit Guaranty Corporation ▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).			ion	This Fo	rm is Open to Public Inspection		
For calendar plan year 20	21 or fiscal pla	n year beginning 08/01/2021		and en	ding 07/3	1/2022	
A Name of plan				B Three	e-digit		
ROCHESTER AREA CO	NSTRUCTION	I AND MATERIALS HEALTH A			number (PN	1) •	501
						,	1
C Plan sponsor's name as shown on line 2a of Form 5500 D Employer Identification Number (EIN)						(EIN)	
ROCHESTER AREA CO	NSTRUCTION	AND MATERIALS HEALTH AND) WELFARE FUND	16-	0962644		
		rning Insurance Contract A. Individual contracts grouped as					
1 Coverage Information:		•				_	
(a) Name of insurance ca	ırrier						
EXCELLUS BLUE CROSS	BLUE SHIEL	D					
	()))))	(1) 0	(e) Approximate nu	mber of		Policy or c	ontract year
(b) EIN	(c) NAIC code	(d) Contract or identification number	persons covered at policy or contract	t end of	(f)	From	(g) To
15-0329043	55107	510454-0001	4		01/01/2021	1	12/31/2021
2 Insurance fee and com descending order of the		ation. Enter the total fees and total	al commissions paid. Li	st in line 3	the agents, I	brokers, and o	other persons in
(a) Total amount of commissions paid (b) Total amount of fees paid							
3 Persons receiving com		ees. (Complete as many entries					
	(a) Name a	and address of the agent, broker,	or other person to whor	n commiss	ions or fees	were paid	
(b) Amount of sales a	nd base	Fee	es and other commission	ns paid			
commissions pa	id	(c) Amount		(d) Purpose	9		(e) Organization code
	(a) Name a	and address of the agent, broker,	or other person to whon	n commiss	ions or fees	were paid	
	. ,		•			•	
(b) Amount of sales a	nd base	Fee	es and other commission	ns paid			
commissions pa	id	(c) Amount		(d) Purpose	Э		(e) Organization code

Schedule A (Form 5500) 2	2021	Page 2 – 1				
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid						
(a) Name and address of the agent, stoker, of other person to whom commissions of feed were para						
		Fees and other commissions paid	(e)			
(b) Amount of sales and base	(a) Amazumt		Organization			
commissions paid	(c) Amount	(d) Purpose	code			
(a) Nar	me and address of the agent, bro	ker, or other person to whom commissions or fees were paid				
(a) (vai	The and address of the agent, bro	Not, of other person to whom commissions of fees were paid				
		Face and other commissions paid	(a)			
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization			
commissions paid	(c) Amount	(d) Purpose	code			
(a) No.	no and address of the agent bro	ker, or other person to whom commissions or fees were paid				
(a) Ivai	ne and address of the agent, bro	ker, or other person to whom commissions or rees were paid				
		Fees and other commissions paid	(e)			
(b) Amount of sales and base	(c) Amount	(d) Purpose	Organization			
commissions paid	(c) Amount	(a) i uipose	code			
(a) Nar	me and address of the agent, bro	ker, or other person to whom commissions or fees were paid				
(4)	no and address of the agent, sie	not, or other personne mem commissions of recording para				
		Fees and other commissions paid	(e)			
(b) Amount of sales and base	(c) Amount	(d) Purpose	Organization			
commissions paid	(c) Amount	(a) i uipose	code			
(a) Nar	me and address of the agent, bro	ker, or other person to whom commissions or fees were paid				
(5)		, с. с				
Fees and other commissions paid (e)						
(b) Amount of sales and base	(a) Amount		Organization			
commissions paid	(c) Amount	(d) Purpose	code			

Schedule A (Form 5500) 2021

Part II		Investment and Annuity Contract Information					
		Where individual contracts are provided, the entire group of such indivi	dual contracts with each carrier ma	y be treated	as a unit for purposes of		
4	Curr	this report. ent value of plan's interest under this contract in the general account at year of the plan's interest under this contract in the general account at year of the plants are the plants.	and	4			
		ent value of plan's interest under this contract in the general accounts at year er		5			
		racts With Allocated Funds:					
Ū	a	State the basis of premium rates					
	_	Clate the same of promisin rates					
	b	Premiums paid to carrier		6b			
	С	Premiums due but unpaid at the end of the year		6c			
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount		6d			
		Specify nature of costs					
	е	Type of contract: (1) ☐ individual policies (2) ☐ group deferred	d annuity				
		(3) other (specify)					
		(e) [] cance (ep cany)					
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, check here				
7		racts With Unallocated Funds (Do not include portions of these contracts mai	<u> </u>				
•			te participation guarantee				
	а		te participation guarantee				
		(3) guaranteed investment (4) dother					
	L			71.			
	b	Balance at the end of the previous year		7b			
	С	Additions: (1) Contributions deposited during the year	7c(1) 7c(2)				
		(2) Dividends and credits	7c(3)				
		(4) Transferred from separate account	7c(4)				
		(5) Other (specify below)	7c(5)				
		b	13(3)				
		<i>'</i>					
		(O)T + 1 - 1 PC		70(6)			
	٨	(6)Total additions		7c(6) 7d			
		Total of balance and additions (add lines 7b and 7c(6)) Deductions:		74			
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)				
		(2) Administration charge made by carrier	7e(2)				
		(3) Transferred to separate account	7e(3)				
		(4) Other (specify below)	7e(4)				
		b					
		,					
				7o/5\			
	_	(5) Total deductions		7e(5)			
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)		7 f			

Part III Welfare Benefit Contract Information If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual				
employees, the entire group of such individual contracts with each c				
Benefit and contract type (check all applicable boxes)				
a X Health (other than dental or vision) b Dental	c ☐ Vision d ☐ Life insurance			
e Temporary disability (accident and sickness) f Long-term disabil	ity g Supplemental unemployment h Prescription drug			
i ☐ Stop loss (large deductible) j ☐ HMO contract	k ☐ PPO contract I ☐ Indemnity contract			
m Other (specify)				
9 Experience-rated contracts:				
a Premiums: (1) Amount received	9a(1)			
(2) Increase (decrease) in amount due but unpaid				
(3) Increase (decrease) in unearned premium reserve	9a(3)			
(4) Earned ((1) + (2) - (3))	9a(4)			
b Benefit charges (1) Claims paid				
(2) Increase (decrease) in claim reserves	9b(2)			
(3) Incurred claims (add (1) and (2))				
(4) Claims charged				
c Remainder of premium: (1) Retention charges (on an accrual basis)				
(A) Commissions	9c(1)(A)			
(B) Administrative service or other fees	9c(1)(B)			
(C) Other specific acquisition costs	9c(1)(C)			
(D) Other expenses	9c(1)(D)			
(E) Taxes	9c(1)(E)			
(F) Charges for risks or other contingencies	9c(1)(F)			
(G) Other retention charges	0 (1)(0)			
(H) Total retention	0.4040			
(2) Dividends or retroactive rate refunds. (These amounts were paid in				
<u>—</u>				
d Status of policyholder reserves at end of year: (1) Amount held to provide				
(2) Claim reserves				
(3) Other reserves	- · · · · · · · · · · · · · · · · · · ·			
Dividends or retroactive rate refunds due. (Do not include amount entere	d in line 9c(2).) 9e			
10 Nonexperience-rated contracts:	40-			
a Total premiums or subscription charges paid to carrier				
b If the carrier, service, or other organization incurred any specific costs in o				
retention of the contract or policy, other than reported in Part I, line 2 above Specify nature of costs.	ve, report amount			
Specify flature of costs.				
Part IV Provision of Information				
11 Did the insurance company fail to provide any information necessary to comp	lete Schedule A? Yes X No			
12 If the answer to line 11 is "Yes," specify the information not provided.				

Department of the Treasury Internal Revenue Service

Department of Labor

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

OMB No. 1210-0110

Employee Benefits Security Ad	Iministration	File as an a	ttacnment to Form 55	00.			
Pension Benefit Guaranty Corporation Insurance companies are required to provide the in pursuant to ERISA section 103(a)(2).							
For calendar plan year 2021 or fiscal plan year beginning 08/01/2021				and en	ding 07/3	1/2022	
A Name of plan ROCHESTER AREA CO	NSTRUCTION	AND MATERIALS HEALTH A			e-digit number (PN	N) •	501
	NSTRUCTION	AND MATERIALS HEALTH AND		16-	0962644	ation Number	
		ning Insurance Contract Individual contracts grouped as					
1 Coverage Information:							
(a) Name of insurance ca	(c) NAIC code	(d) Contract or identification number	(e) Approximate nu persons covered a	t end of	(f)	Policy or From	contract year (g) To
20-2888723	55107	317428	policy or contrac	t year	01/01/2021		12/31/2021
descending order of the	e amount paid. amount of comi	missions paid ees. (Complete as many entries and address of the agent, broker,	as needed to report all	(b) To	otal amount o	of fees paid	other persons in
		Foo	s and other commission	ne paid			
(b) Amount of sales an commissions pa		(c) Amount	ees and other commissions paid (d) Purpose			(e) Organization code	
	(a) Name a	and address of the agent, broker,	or other person to who	m commiss	ions or fees	were paid	
(b) Amount of soles of							
(b) Amount of sales an commissions pa	id	(c) Amount	es and other commissions paid (d) Purpose		(e) Organization code		
For Panerwork Reduction	on Act Notice	see the Instructions for Form 5	500			Sch	edule A (Form 5500) 2021

Schedule A (Form 5500) 2	2021	Page 2 – 1					
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid							
	T						
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization				
commissions paid	(c) Amount	(d) Purpose	code				
(a) Nai	me and address of the agent, broke	er, or other person to whom commissions or fees were paid					
	T						
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization				
commissions paid	(c) Amount	(d) Purpose	code				
(a) Nai	me and address of the agent, broke	er, or other person to whom commissions or fees were paid					
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization				
commissions paid	(c) Amount	(d) Purpose	code				
(a) Nai	me and address of the agent, broke	er, or other person to whom commissions or fees were paid					
			ı				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization				
commissions paid	(c) Amount	(d) Purpose	code				
(a) Nai	me and address of the agent, broke	er, or other person to whom commissions or fees were paid					
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization				
commissions paid	(c) Amount	(d) Purpose	code				

Schedule A (Form 5500) 2021

	Part		idual contracto with cook corrier mou	ha traataa	log a unit for nurnage of
		Where individual contracts are provided, the entire group of such individual this report.	idual contracts with each camer may	De liealec	i as a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end	4	
5	Curr	ent value of plan's interest under this contract in separate accounts at year e	nd	5	
6	Con	tracts With Allocated Funds:			
	а	State the basis of premium rates			
			1		
	b	Premiums paid to carrier		6b	
	C	Premiums due but unpaid at the end of the year		6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount	•	6d	
		Specify nature of costs			
		oposity flature of society			
	е	Type of contract: (1) individual policies (2) group deferred	d annuity		
			a armany		
		(3) other (specify)			
_	<u> </u>	If contract purchased, in whole or in part, to distribute benefits from a termin	<u> </u>		
1		tracts With Unallocated Funds (Do not include portions of these contracts ma			
	а		ate participation guarantee		
		(3) guaranteed investment (4) other			
	b	Balance at the end of the previous year		7b	
	С	Additions: (1) Contributions deposited during the year	7c(1)		
		(2) Dividends and credits	7c(2)		
		(3) Interest credited during the year	7c(3)		
		(4) Transferred from separate account	7c(4) 7c(5)		
		(5) Other (specify below)	70(3)		
		•			
				7 - (0)	
		(6)Total additions		7c(6)	
		Total of balance and additions (add lines 7b and 7c(6))		7d	
	E	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
		(2) Administration charge made by carrier	7e(2)		
		(3) Transferred to separate account	7e(3)		
		(4) Other (specify below)	7e(4)		
		•	- (- /		
		,			
		(E) Total de destace		70/F)	
	£	(5) Total deductions	ı	7e(5) 7f	
	I	Balance at the end of the current year (subtract line 7e(5) from line 7d)		11	

Welfare Benefit Contract Information Welfare Benefit Contract Information Welfare Benefit Contract Information in many be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual exhibits with exhibit contract view in the purpose of this report. 8 Benefit during the contract view of the property of the property of the purpose of the report of the purpose of the purpose of the report of the purpose o								
A Health (other than dental or vision) B Dental C Vision d Life insurance	Part III	If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual						
e	8 Benefit a	nd contract type (check all applicable boxes)						
e	а 🛛 не	ealth (other than dental or vision)	b ☐ Dental		сП	Vision		d ☐ Life insurance
i			=		ш		nlovment	=
Pert IV Provision of Information Sexperience-rated contracts: Sexperience-rated contract	. =		- =				pioyineni	
9 Experience-rated contracts: a Premiums: (1) Amount received	<u> </u>		I HMO contract		ĸ∐	PPO contract		I Indemnity contract
a Premiums: (1) Amount received. (2) Increase (decrease) in amount due but unpaid. (3) Increase (decrease) in uneamed premium reserve. (4) Earned ((1) + (2) - (3)). (5) Benefit charges (1) Claims patd. (6) Increase (decrease) in claim reserves. (7) Increase (decrease) in claim reserves. (8) Increase (decrease) in claim reserves. (9b(1) (9b(3) (4) Claims charged. (A) Commissions. (B) Administrative service or other fees. (C) Other spenific adquistion costs. (C) Other spenific adquistion costs. (E) Taxes. (F) Charges for risks or other contingencies. (B) Administrative service or other fees. (C) Other spenific adquistion costs. (E) Taxes. (F) Charges for risks or other contingencies. (B) Administrative service. (C) Other spenific adquistion costs. (D) Other responses. (E) Taxes. (F) Charges for risks or other contingencies. (C) Other factorion. (C) Other spenific adquistion. (C) Other spenific adquistion. (D) Other responses. (E) Total retention. (D) Other responses. (E) Other spenific adduistion. (D) Other responses. (E) Other spenific adduistion. (D) Other responses. (E) Other spenific adduistion. (D) Other responses. (E) Other responses. (D) Other responses. (E) Other responses. (D) Other response adduistion. (D) Ot	m [] Ot	her (specify)						
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(2) Increase (decrease) in claim reserves. (3) Incurred claims (add (1) and (2)). (4) Claims charged. (B) Administrative service or other fees. (B) Administrative service or other fees. (C) Other specific acquisition costs. (B) Administrative service or other fees. (C) Other specific acquisition costs. (D) Other expenses. (E) Taxes. (E) Taxes. (F) Charges for risks or other contingencies. (B) Colly (C) (C) Other retention charges. (C) Other retention charges. (C) Other retention and preserves. (D) Other retention and preserves. (E) Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2)). (D) Other reserves. (E) Taxes. (D) Other reserves. (E) Taxes. (D) Other reserves. (E) Othe							. 9a(4)	
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C Remainder of premium: (1) Retention charges (on an accrual basis) (A) Commissions. (B) Administrative service or other fees	` ,	` ` ` ` ` ` ` ' ' ' ' ' ' ' ' ' ' ' ' '					_ ` /	
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(B) Administrative service or other fees 9c(1)(B) 9c(1)(C) 9c(1)(B) 9c(1)(C) 9c(1)(. , ,	,	0 (1)(
(C) Other specific acquisition costs. (D) Other expenses (E) Taxes. (F) Charges for risks or other contingencies. (F) Charges for risks or other contingencies. (G) Other retention charges. (P) Dividends or retroactive rate refunds. (These amounts were paid in cash, or credited). (2) Dividends or retroactive rate refunds. (These amounts were paid in cash, or dividends or retroactive rate refunds. (These amounts were paid in cash, or dividends or retroactive rate refunds. (These amounts were paid in cash, or dividends). (B) Other reserves. (C) Claim reserves. (D) Dividends or retroactive rate refunds due. (Do not include amount entered in line sec(2)). (E) Dividends or retroactive rate refunds due. (Do not include amount entered in line sec(2)). (E) Dividends or retroactive rate refunds due. (Do not include amount entered in line sec(2)). (E) Claim reserves. (D) Other reserves. (E) Othe								
(D) Other expenses		` '						
(E) Taxes. (F) Charges for risks or other contingencies. (G) Other retention charges. (H) Total retention. (2) Dividends or retroactive rate refunds. (These amounts were paid in cash, or credited.) (2) Claim reserves at end of year: (1) Amount held to provide benefits after retirement. (2) Claim reserves. (3) Other reserves. (4) Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2)). (5) Other reserves. (6) Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2)). (6) Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2)). (B) Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2)). (C) Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2)). (D) Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2)). (D) Dividends or retroactive rate refunds due. (D) Div		` , ' '						
(F) Charges for risks or other contingencies (G) Other retention charges (H) Total retention (P) Total re		` , '						
(G) Other retention charges		` ',						
(H) Total retention		. ,		- (1)(1				
(2) Dividends or retroactive rate refunds. (These amounts were paid in cash, or credited.)		•					0.40410	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement		` '	_		_)
(2) Claim reserves					_		9c(2)	
(3) Other reserves			•					
e Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).)	(2) (Claim reserves					9d(2)	
Total premiums or subscription charges paid to carrier	(3) (Other reserves					9d(3)	
a Total premiums or subscription charges paid to carrier		,	ot include amount entere	d in line 9	c(2) .))	9e	
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount								
retention of the contract or policy, other than reported in Part I, line 2 above, report amount	a Tota	al premiums or subscription charges paid to o	arrier				10a	
Part IV Provision of Information 11 Did the insurance company fail to provide any information necessary to complete Schedule A?								
Part IV Provision of Information 11 Did the insurance company fail to provide any information necessary to complete Schedule A?			orted in Part I, line 2 abov	ve, report	amou	unt	10b	
11 Did the insurance company fail to provide any information necessary to complete Schedule A?	Specify	lature or costs.						
11 Did the insurance company fail to provide any information necessary to complete Schedule A?								
11 Did the insurance company fail to provide any information necessary to complete Schedule A?								
11 Did the insurance company fail to provide any information necessary to complete Schedule A?								
11 Did the insurance company fail to provide any information necessary to complete Schedule A?								
11 Did the insurance company fail to provide any information necessary to complete Schedule A?								
11 Did the insurance company fail to provide any information necessary to complete Schedule A?								
11 Did the insurance company fail to provide any information necessary to complete Schedule A?								
11 Did the insurance company fail to provide any information necessary to complete Schedule A?								
11 Did the insurance company fail to provide any information necessary to complete Schedule A?								
11 Did the insurance company fail to provide any information necessary to complete Schedule A?								
11 Did the insurance company fail to provide any information necessary to complete Schedule A?	-							
	Part IV	Provision of Information						
12 If the answer to line 11 is "Yes," specify the information not provided.	11 Did the	insurance company fail to provide any inform	nation necessary to comp	lete Sche	dule .	A?	Yes	X No

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

File as an attachment to Form 5500.

OMB No. 1210-0110

Employee Benefits Security Administration / The default attacks and attacks an							
Pension Benefit Guaranty Corporation Insurance companies are required to provide to pursuant to ERISA section 103(a)(2)				ion	This For	m is Open to Public Inspection	
For calendar plan year 2021 or fiscal plan year beginning 08/01/2021 and endir					ding 07/3	1/2022	
A Name of plan				B Three	e-digit		
ROCHESTER AREA CONSTRUCTION AND MATERIALS HEALTH A					number (PN	1) •	501
						,	
C Plan sponsor's name a	as shown on lin	e 2a of Form 5500		D Emplo	ver Identific	ation Number	(EIN)
·		AND MATERIALS HEALTH AND	O WELFARE FUND		0962644		,
		rning Insurance Contract a. Individual contracts grouped a					
1 Coverage Information:		¥ :		•			
(a) Name of insurance ca	rrier						
EXCELLUS HEALTH PLA	N						
	(a) NIAIC	(4) Contract or	(e) Approximate nu	ımber of		Policy or c	ontract year
(b) EIN	(c) NAIC code	(d) Contract or identification number	persons covered a policy or contrac	t end of	(f)	From	(g) To
	55107	6325035	152		01/01/2021	1	12/31/2021
2 Insurance fee and com descending order of the		ation. Enter the total fees and tot	al commissions paid. L	ist in line 3	the agents,	brokers, and c	ther persons in
(a) Total	amount of com	missions paid		(b) To	tal amount	of fees paid	
3 Persons receiving com		ees. (Complete as many entries					
	(a) Name a	and address of the agent, broker,	or other person to who	n commiss	ions or rees	were paid	
(b) Amount of sales a	nd base	Fee	es and other commission	ns paid			
commissions pa	id	(c) Amount		(d) Purpose	9		(e) Organization code
	(a) Name a	and address of the agent, broker,	or other person to who	m commiss	ions or fees	were paid	
(b) Amount of sales a	nd base	Fee	es and other commission	ns paid			
commissions pa	id	(c) Amount		(d) Purpose	9		(e) Organization code
	A (N) ((= =====

Schedule A (Form 5500) 2	2021	Page 2 –	1	
(a) Nar	me and address of the agent, broker,	or other person to whom com	umissions or fees were paid	
(a) Nai	ne and address of the agent, broker,	, or other person to whom com	imissions of fees were paid	
		Fees and other commissions p	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount		d) Purpose	Organization code
(a) Nar	me and address of the agent, broker,	, or other person to whom com	nmissions or fees were paid	-
				1
(b) Amount of sales and base		Fees and other commissions p	paid	(e) Organization
commissions paid	(c) Amount	(0	d) Purpose	code
(a) Nar	me and address of the agent, broker,	, or other person to whom com	nmissions or fees were paid	
(b) Amount of sales and base	 	Fees and other commissions p	paid	(e) Organization
commissions paid	(c) Amount	(c	d) Purpose	code
(a) Nar	me and address of the agent, broker,	, or other person to whom com	nmissions or fees were paid	
(b) Amount of sales and base	<u> </u>	Fees and other commissions p	paid	(e) Organization
commissions paid	(c) Amount	(0	d) Purpose	code
(a) Nar	me and address of the agent, broker,	or other person to whom com	nmissions or fees were paid	
(-)	To and address of the agon, stone,	, 6- 5		
424		Fees and other commissions p	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code

Schedule A (Form 5500) 2021

F	Part I				
		Where individual contracts are provided, the entire group of such indivithis report.	dual contracts with e	ach carrier may be treated as a ur	nit for purposes of
4	Curre	ent value of plan's interest under this contract in the general account at year	end	4	
_		ent value of plan's interest under this contract in separate accounts at year en			
_		racts With Allocated Funds:		1	
	а	State the basis of premium rates			
	b	Premiums paid to carrier		6b	
	С	Premiums due but unpaid at the end of the year		6c	
	d	If the carrier, service, or other organization incurred any specific costs in cor	nnection with the acq	uisition or 6d	
		retention of the contract or policy, enter amount			
		Specify nature of costs			
	е	Type of contract: (1) individual policies (2) group deferred	d annuity		
		(3) other (specify)			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, check he	re 🕨 🗌	
7	Conti	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in separate	accounts)	
	а	_ `	te participation guara		
		(3) ☐ guaranteed investment (4) ☐ other ▶			
		(e) [] gastaneou missanen (i) [] tarisi v			
	b	Balance at the end of the previous year		7b	
	C	Additions: (1) Contributions deposited during the year	7c(1)		
		(2) Dividends and credits	7c(2)		
		(3) Interest credited during the year	7c(3)		
		(4) Transferred from separate account	7c(4)		
		(5) Other (specify below)	7c(5)		
		•			
		(6)Total additions		7c(6)	
	d ·	Total of balance and additions (add lines 7b and 7c(6))			
	e [Deductions:			
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
		(2) Administration charge made by carrier	7e(2)		
		(3) Transferred to separate account	7e(3)		
		(4) Other (specify below)	7e(4)		
		•			
		(5) Total deductions		7e(5)	
		Balance at the end of the current year (subtract line 7e(5) from line 7d)			

Pai	rt III	Welfare Benefit Contract Information one contract covers the same the information may be combined for report	group of employees of the	e same e tracts are	mplo	oyer(s) or members of erience-rated as a uni	the same e	mployee organiza	ations(s), ividual
		employees, the entire group of such individ							
8 B	enefit a	nd contract type (check all applicable boxes)							
а	ı 🗌 He	ealth (other than dental or vision)	b X Dental		С	Vision		d Life insura	nce
е	• 🗌 Te	emporary disability (accident and sickness)	f Long-term disabili	ity	g	Supplemental unem	ployment	h Prescription	n drug
i	St	op loss (large deductible)	j HMO contract		kΠ	PPO contract		I Indemnity	contract
n	_	ther (specify)	- 🗀			1			
-	⊔ ~	inor (openity)							
9 F	xperien	ce-rated contracts:							
	•	niums: (1) Amount received		9a(1)				
		ncrease (decrease) in amount due but unpaid							
		ncrease (decrease) in unearned premium res		-	_				
	` '	Earned ((1) + (2) - (3))					9a(4)		
ı		nefit charges (1) Claims paid							
		ncrease (decrease) in claim reserves			-				
		ncurred claims (add (1) and (2))					9b(3)		
	. ,	Claims charged					9b(4)		
(C Rer	nainder of premium: (1) Retention charges (c	n an accrual basis)						
		(A) Commissions		9c(1)(A)				
		(B) Administrative service or other fees		9c(1)(B)				
		(C) Other specific acquisition costs		9c(1)(C)				
		(D) Other expenses		9c(1)(
		(E) Taxes		9c(1)(E)				
		(F) Charges for risks or other contingencies .		9c(1)(
		(G) Other retention charges		9c(1)(G)		_		
		(H) Total retention					9c(1)(H)		
	(2)	Dividends or retroactive rate refunds. (These	amounts were paid in	n cash, oi	r 🗌 d	credited.)	9c(2)		
(d Stat	tus of policyholder reserves at end of year: (1) Amount held to provide	benefits	after	retirement	9d(1)		
	(2)	Claim reserves					9d(2)		
	(3)	Other reserves					9d(3)		
•	e Divi	dends or retroactive rate refunds due. (Do n	ot include amount entere	d in line 9	c(2).	.)	9e		
10	Nonexp	perience-rated contracts:							
6	a Tota	al premiums or subscription charges paid to c	arrier				10a		1
ı		e carrier, service, or other organization incuri							
_	rete	ntion of the contract or policy, other than rep	orted in Part I, line 2 abov	e, report	amo	ount	10b		
S	pecify r	nature of costs.							
Par	rt IV	Provision of Information							
11	Did the	insurance company fail to provide any inform	ation necessary to comp	lete Sche	edule	A?	Yes	X No	
	12 If the answer to line 11 is "Yes," specify the information not provided.								

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

File as an attachment to Form 5500.

OMB No. 1210-0110

Employee Belletie Geeding 716							
Pension Benefit Guaranty Corporation Insurance companies are required to provide the pursuant to ERISA section 103(a)(2)				ion	This Fo	m is Open to Public Inspection	
For calendar plan year 2021 or fiscal plan year beginning 08/01/2021 an					ding 07/31	/2022	
A Name of plan ROCHESTER AREA CONSTRUCTION AND MATERIALS HEALTH					e-digit number (PN)) •	501
C Plan sponsor's name a		e 2a of Form 5500 AND MATERIALS HEALTH AN	ID WELFARE FUND		oyer Identifica 0962644	tion Number	(EIN)
		rning Insurance Contrac Lindividual contracts grouped a					
1 Coverage Information:							
(a) Name of insurance ca	(c) NAIC	(d) Contract or	(e) Approximate nu			Policy or c	ontract year
(b) EIN	code	identification number	persons covered at policy or contract		(f)	From	(g) To
20-2888723	55107	317428	4	you	01/01/2021		12/31/2021
descending order of the	amount paid.	ation. Enter the total fees and to	tal commissions paid. Lis				ther persons in
(a) Total	amount of com	missions paid		(b) To	otal amount o	f fees paid	
3 Persons receiving com	missions and f	ees. (Complete as many entries	s as needed to report all p	persons).			
	(a) Name a	and address of the agent, broker	, or other person to whon	n commiss	ions or fees v	were paid	
(b) Amount of sales a	nd hase	Fe	es and other commission	s paid			
commissions pa		(c) Amount		(d) Purpose			(e) Organization code
	(a) Name a	and address of the agent, broker	or other person to whom	n commiss	ions or fees v	were naid	
	(a) Name a	and address of the agent, broker	, or other person to whom	T COMMISS	ions of fees v	vere paid	
(h) Amount of color -	ad boos	Fe	es and other commission	s paid			
(b) Amount of sales a commissions pa		(c) Amount		d) Purpose	e		(e) Organization code
			,	, , , , ,			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
		· · · · · · · · · · · · · · · · · · ·					•

Schedule A (Form 5500) 2	2021	Page 2 – 1					
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid							
(4)							
		Foos and other commissions naid		(0)			
(b) Amount of sales and base		Fees and other commissions paid		(e) Organization			
commissions paid	(c) Amount	(d) Pu	ipose	code			
(a) Na	me and address of the agent, broker	or other person to whom commiss	zione or fees were naid				
(a) Ivai	The and address of the agent, broker	, or other person to whom commiss	sions of fees were paid				
(b) Amount of sales and base		Fees and other commissions paid		(e) Organization			
commissions paid	(c) Amount	(d) Pu	rpose	code			
(a) Nar	me and address of the agent, broker	, or other person to whom commiss	sions or fees were paid				
(h) Associat of color and book		Fees and other commissions paid		(e)			
(b) Amount of sales and base commissions paid	(c) Amount	(d) Pu	rpose	Organization code			
(a) Nar	me and address of the agent, broker	or other person to whom commiss	sions or fees were paid				
[4]	no and address of the agent, pronor	, or other person to whom comme	Note of 1888 Well part				
(h) Associat of color and book		Fees and other commissions paid		(e)			
(b) Amount of sales and base commissions paid	(c) Amount	(d) Pu	rpose	Organization code			
(a) No.	me and address of the agent, broker	or other person to whom commiss	rions or foos wore paid				
(a) Ival	The and address of the agent, bloker	, or other person to whom commiss	ions of fees were paid				
		Fees and other commissions paid		(e)			
(b) Amount of sales and base commissions paid	(c) Amount	(d) Pu	rpose	Organization code			
22paid							

Schedule A (Form 5500) 2021

ı	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indiv	idual contracts with each carrier may	be treated	l as a unit for purposes of
		this report.		1 1	- ac a a.m. ici pai pocco ci
		ent value of plan's interest under this contract in the general account at year		4	
_		ent value of plan's interest under this contract in separate accounts at year e	nd	5	
О		tracts With Allocated Funds:			
	а	State the basis of premium rates			
	b	Premiums paid to carrier		6b	
	C	Premiums due but unpaid at the end of the year		6c	
	d	If the carrier, service, or other organization incurred any specific costs in co		6d	
		retention of the contract or policy, enter amount	·	o u	
		Specify nature of costs			
	е	Type of contract: (1) individual policies (2) group deferre	d annuity		
		(3) other (specify)			
	f	If contract purchased, in whole or in part, to distribute benefits from a terminate	nating plan, check here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	aintained in separate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	ate participation guarantee		
		(3) guaranteed investment (4) other	•		
	b	Balance at the end of the previous year		7b	
	С	Additions: (1) Contributions deposited during the year			
		(2) Dividends and credits	7c(2)		
		(3) Interest credited during the year			
		(4) Transferred from separate account			
		(5) Other (specify below)	7c(5)		
		•			
				- (a)	
	-1	(6)Total additions		7c(6)	
		Total of balance and additions (add lines 7b and 7c(6)).		7d	
	E	Deductions: (1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
		(2) Administration charge made by carrier	7e(2)		
		(3) Transferred to separate account	- (0)		
		(4) Other (specify below)	7e(4)		
		•			
		(E) Total deductions		7e(5)	
	f	(5) Total deductions		7 6 (3)	
	-			1	

Part III Welfare Benefit Contract Information If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.					
8 Benefit and contract type (check all applicable boxes)	_				
a X Health (other than dental or vision) b ☐ Dental	C ☐ Vision d ☐ Life insurance				
e ☐ Temporary disability (accident and sickness) f ☐ Long-term disabi	lity g Supplemental unemployment h Prescription drug				
i Stop loss (large deductible) j HMO contract	k ☐ PPO contract I ☐ Indemnity contract				
m ☐ Other (specify) ▶					
9 Experience-rated contracts:					
a Premiums: (1) Amount received	92(1)				
(2) Increase (decrease) in amount due but unpaid	9a(1) 9a(2)				
(3) Increase (decrease) in unearned premium reserve					
(4) Earned ((1) + (2) - (3))					
b Benefit charges (1) Claims paid					
(2) Increase (decrease) in claim reserves	21 (2)				
(3) Incurred claims (add (1) and (2))					
(4) Claims charged	2.70				
C Remainder of premium: (1) Retention charges (on an accrual basis)					
(A) Commissions	9c(1)(A)				
(B) Administrative service or other fees	9c(1)(B)				
(C) Other specific acquisition costs	9c(1)(C)				
(D) Other expenses	9c(1)(D)				
(E) Taxes	9c(1)(E)				
(F) Charges for risks or other contingencies					
(G) Other retention charges	·				
(H) Total retention	_				
(2) Dividends or retroactive rate refunds. (These amounts were paid	in cash, or credited.)				
d Status of policyholder reserves at end of year: (1) Amount held to provide	e benefits after retirement				
(2) Claim reserves	9d(2)				
(3) Other reserves	9d(3)				
e Dividends or retroactive rate refunds due. (Do not include amount entere	ed in line 9c(2).)				
10 Nonexperience-rated contracts:					
a Total premiums or subscription charges paid to carrier	10a				
b If the carrier, service, or other organization incurred any specific costs in retention of the contract or policy, other than reported in Part I, line 2 abo	connection with the acquisition or ove, report amount				
Specify nature of costs. Provision of Information					
Part IV Provision of Information					
11 Did the insurance company fail to provide any information necessary to complete Schedule A?					
12 If the answer to line 11 is "Yes," specify the information not provided.					

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

File as an attachment to Form 5500.

OMB No. 1210-0110

Employee Benefits Security Ad	IIIIIIIStration	, , , , , , ,					
Pension Benefit Guaranty Corporation Insurance companies are required to provide the pursuant to ERISA section 103(a)(2).			ion	This For	m is Open to Public Inspection		
For calendar plan year 20	21 or fiscal pla	n year beginning 08/01/2021		and en	ding 07/3	1/2022	
A Name of plan				B Three	e-digit		
ROCHESTER AREA CO	NSTRUCTION	I AND MATERIALS HEALTH A			number (PN	1) 🕨	501
				<u> </u>		,	1
·	C Plan sponsor's name as shown on line 2a of Form 5500 D Employer Identification Number (EIN)						(EIN)
ROCHESTER AREA CO	NSTRUCTION	AND MATERIALS HEALTH AND	O WELFARE FUND	16-	0962644		
		rning Insurance Contract A. Individual contracts grouped as					
1 Coverage Information:		•					
(a) Name of insurance ca	ırrier						
EXCELLUS BLUE CROSS	BLUE SHIEL	D					
	(-) NIAIO	(A) Construct on	(e) Approximate nu	mber of		Policy or c	ontract year
(b) EIN	(c) NAIC code	(d) Contract or identification number	persons covered at policy or contract	end of	(f)	From	(g) To
15-0329043	55107	501410-0001	8		01/01/2021	I	12/31/2021
2 Insurance fee and com descending order of the		ation. Enter the total fees and tota	al commissions paid. Lis	st in line 3	the agents, I	brokers, and c	ther persons in
(a) Total	amount of com	missions paid		(b) To	otal amount o	of fees paid	
3 Persons receiving com		ees. (Complete as many entries and address of the agent, broker,			ions or facs	were naid	
	,,	•				,	
(b) Amount of sales a	nd base	Fee	es and other commission	s paid			
commissions pa	id	(c) Amount	(d) Purpose	9		(e) Organization code
	(a) Name a	and address of the agent, broker,	or other person to whon	n commiss	ions or fees	were paid	
(b) Amount of sales a	nd base	Fee	es and other commission	s paid			
commissions pa		(c) Amount	(d) Purpose	Э		(e) Organization code

Schedule A (Form 5500) 2	2021	Page 2 – 1	
(a) Na	me and address of the agent, bro	oker, or other person to whom commissions or fees were paid	
	Г		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	me and address of the agent, bro	oker, or other person to whom commissions or fees were paid	
	T		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	me and address of the agent, bro	oker, or other person to whom commissions or fees were paid	
	ı		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	me and address of the agent, bro	oker, or other person to whom commissions or fees were paid	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	me and address of the agent, bro	oker, or other person to whom commissions or fees were paid	
	-		
			I
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
	l	1	I

Schedule A (Form 5500) 2021

F	Part				
		Where individual contracts are provided, the entire group of such indivi	dual contracts with	n each carrier may be tre	ated as a unit for purposes of
1	Curr	this report. ent value of plan's interest under this contract in the general account at year.	end	4	
		ent value of plan's interest under this contract in the general accounts at year e			
_		racts With Allocated Funds:			<u>_</u>
Ŭ	a	State the basis of premium rates			
	_	Clate the basic of promisin rates 7			
	b	Premiums paid to carrier		6b	<u> </u>
	С	Premiums due but unpaid at the end of the year		_	
	d	If the carrier, service, or other organization incurred any specific costs in cor	nnection with the a	cquisition or 60	1
		retention of the contract or policy, enter amount			<u>'</u>
		Specify nature of costs			
	е	Type of contract: (1) individual policies (2) group deferred	d annuity		
		(3) other (specify)			
		_			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, check h	nere 🕨 🗌	
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in separat	e accounts)	
	а		te participation gu		
		(3) ☐ guaranteed investment (4) ☐ other ▶			
		(b) [] guaranteed investment (1) [] ether y			
	b	Balance at the end of the previous year			, [
	c	Additions: (1) Contributions deposited during the year	7c(1)		
	_	(2) Dividends and credits	7c(2)		
		(3) Interest credited during the year	7c(3)		
		(4) Transferred from separate account	7c(4)		
		(5) Other (specify below)	7c(5)		
		>			
		(6)Total additions		7c(6)
	d	Total of balance and additions (add lines 7b and 7c(6)).			
	е	Deductions:			
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
		(2) Administration charge made by carrier	7e(2)		
		(3) Transferred to separate account	7e(3)		
		(4) Other (specify below)	7e(4)		
		•			
		(5) Total deductions		7e(5)
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			

	e same employer(s) or members of the same employee organizations(s), tracts are experience-rated as a unit. Where contracts cover individual arrier may be treated as a unit for purposes of this report.					
8 Benefit and contract type (check all applicable boxes)						
a X Health (other than dental or vision) b ☐ Dental	c ☐ Vision d ☐ Life insurance					
e ☐ Temporary disability (accident and sickness) f ☐ Long-term disabil	ity g Supplemental unemployment h Prescription drug					
i ☐ Stop loss (large deductible) j ☐ HMO contract	k ☐ PPO contract I ☐ Indemnity contract					
m ☐ Other (specify) ▶						
III Ushediy)						
9 Experience-rated contracts:						
a Premiums: (1) Amount received	9a(1)					
(2) Increase (decrease) in amount due but unpaid	9a(2)					
(3) Increase (decrease) in unearned premium reserve						
(4) Earned ((1) + (2) - (3))						
b Benefit charges (1) Claims paid	9b(1)					
(2) Increase (decrease) in claim reserves	9b(2)					
(3) Incurred claims (add (1) and (2))	9b(3)					
(4) Claims charged	9b(4)					
c Remainder of premium: (1) Retention charges (on an accrual basis)						
(A) Commissions	9c(1)(A)					
(B) Administrative service or other fees	9c(1)(B)					
(C) Other specific acquisition costs	9c(1)(C)					
(D) Other expenses	9c(1)(D) 9c(1)(E)					
(E) Taxes	9c(1)(F)					
(F) Charges for risks or other contingencies	0 (1)(0)					
(H) Total retention	6 (0)					
(2) Dividends or retroactive rate refunds. (These amounts were paid in	. 🗖					
d Status of policyholder reserves at end of year: (1) Amount held to provide						
(2) Claim reserves						
(3) Other reserves	2 1/2					
Dividends or retroactive rate refunds due. (Do not include amount entere						
10 Nonexperience-rated contracts:						
a Total premiums or subscription charges paid to carrier	10a					
b If the carrier, service, or other organization incurred any specific costs in a retention of the contract or policy, other than reported in Part I, line 2 above Specify nature of costs.	connection with the acquisition or					
Part IV Provision of Information						
11 Did the insurance company fail to provide any information necessary to complete Schedule A?						
12 If the answer to line 11 is "Yes," specify the information not provided.						

Department of the Treasury Internal Revenue Service

Department of Labor

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

OMB No. 1210-0110

Employee Benefits Security Ad	ministration	File as an a	File as an attachment to Form 5500.				
Pension Benefit Guaranty Co	orporation		are required to provide the information ERISA section 103(a)(2).			This Form is Open to Public Inspection	
For calendar plan year 20	21 or fiscal pla	n year beginning 08/01/2021		and en	ding 07/3	1/2022	
A Name of plan ROCHESTER AREA CO	NSTRUCTION	AND MATERIALS HEALTH A		B Three	e-digit number (PI	N) •	501
C Plan sponsor's name a	is shown on lin	e 2a of Form 5500		D Emplo	yer Identific	ation Number (EIN)
ROCHESTER AREA CO	NSTRUCTION	AND MATERIALS HEALTH ANI	D WELFARE FUND	16-	0962644		
		rning Insurance Contract . Individual contracts grouped a					
1 Coverage Information:							
(a) Name of insurance ca							
	(c) NAIC	(d) Contract or	(e) Approximate nu	umber of		Policy or co	ontract year
(b) EIN	code	identification number	persons covered a policy or contract		(f)	From	(g) To
86-2598882	85090	G-3263	250		01/01/202	1	12/31/2021
2 Insurance fee and com descending order of the		ation. Enter the total fees and tot	al commissions paid. L	ist in line 3	the agents,	brokers, and o	ther persons in
(a) Total a	amount of com	missions paid		(b) To	tal amount	of fees paid	
		5767					
3 Persons receiving com		ees. (Complete as many entries					
		and address of the agent, broker,	or other person to who	m commiss	ions or fees	were paid	
UPSTATE FINANCIAL SE	RVICES		VEST GENESEE STRE CUSE, NY 13219	ET SUITE	115		
(b) Amount of sales ar	nd base	Fee	es and other commission	ns paid			
commissions pa		(c) Amount		(d) Purpose			(e) Organization code
	5767						3
	(a) Name a	and address of the agent, broker,	or other person to who	m commiss	ions or fees	were paid	
(b) Amount of sales and base Fees and other commi		es and other commission	ns paid				
commissions pa		(c) Amount		(d) Purpose			(e) Organization code
For Paperwork Reduction	n Act Notice.	see the Instructions for Form 5	5500.			Sched	dule A (Form 5500) 2021

Schedule A (Form 5500) 2	2021	Page 2 – 1				
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid						
		Food and other commissions poid	(0)			
(b) Amount of sales and base commissions paid	(c) Amount	Fees and other commissions paid (d) Purpose	(e) Organization code			
())						
(a) Nar	me and address of the agent, broker	r, or other person to whom commissions or fees were paid				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization			
commissions paid	(c) Amount	(d) Purpose	code			
(a) Nar	me and address of the agent, broker	r, or other person to whom commissions or fees were paid				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization			
commissions paid	(c) Amount	(d) Purpose	code			
(a) Nar	me and address of the agent, broker	r, or other person to whom commissions or fees were paid				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization			
commissions paid	(c) Amount	(d) Purpose	code			
(a) Nar	me and address of the agent. broker	r, or other person to whom commissions or fees were paid				
		Fees and other commissions paid	(e)			
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code			

Schedule A (Form 5500) 2021

	Part		idual contracto with cook corrier mou	ha traataa	log a unit for nurnage of
		Where individual contracts are provided, the entire group of such individual this report.	idual contracts with each camer may	De liealec	i as a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end	4	
5	Curr	ent value of plan's interest under this contract in separate accounts at year e	nd	5	
6	Con	tracts With Allocated Funds:			
	а	State the basis of premium rates			
			1		
	b	Premiums paid to carrier		6b	
	C	Premiums due but unpaid at the end of the year		6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount	•	6d	
		Specify nature of costs			
		oposity flature of society			
	е	Type of contract: (1) individual policies (2) group deferred	d annuity		
			a armany		
		(3) other (specify)			
_	<u> </u>	If contract purchased, in whole or in part, to distribute benefits from a termin	<u> </u>		
1		tracts With Unallocated Funds (Do not include portions of these contracts ma			
	а		ate participation guarantee		
		(3) guaranteed investment (4) other			
	b	Balance at the end of the previous year		7b	
	С	Additions: (1) Contributions deposited during the year	7c(1)		
		(2) Dividends and credits	7c(2)		
		(3) Interest credited during the year	7c(3)		
		(4) Transferred from separate account	7c(4) 7c(5)		
		(5) Other (specify below)	70(3)		
		•			
				7 - (0)	
		(6)Total additions		7c(6)	
		Total of balance and additions (add lines 7b and 7c(6))		7d	
	E	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
		(2) Administration charge made by carrier	7e(2)		
		(3) Transferred to separate account	7e(3)		
		(4) Other (specify below)	7e(4)		
		•	- (- /		
		,			
		(E) Total de destace		70/F)	
	£	(5) Total deductions	ı	7e(5) 7f	
	I	Balance at the end of the current year (subtract line 7e(5) from line 7d)		11	

P	art III	Welfare Benefit Contract Inform If more than one contract covers the same the information may be combined for repor	group of employees of the ting purposes if such conf	racts are exp	erience-rated as	s a unit. Where co	ontracts cover individual	
		employees, the entire group of such individ		arrier may be	treated as a uni	it for purposes of t	this report.	
8		nd contract type (check all applicable boxes)	_	_	_		_	
	a He	ealth (other than dental or vision)	b Dental	С	Vision		d Life insurance	
	e \square Te	emporary disability (accident and sickness)	f Long-term disabili	ty g	Supplemental	unemployment	h Prescription drug	
	i 🗏 St	op loss (large deductible)	j HMO contract	k [PPO contract		I Indemnity contract	
			· —	[
	m X O	ther (specify) ACCIDENTAL DEATH ANI	D DISMEMBERMENT					
_								
9	'	ce-rated contracts:		0-(4)	I		_	
		niums: (1) Amount received		9a(1)			_	
		ncrease (decrease) in amount due but unpai		9a(2)			_	
		ncrease (decrease) in unearned premium re		9a(3)		0-(4)		
	. ,	Earned ((1) + (2) - (3))			 I	9a(4)		
		efit charges (1) Claims paid						
		ncrease (decrease) in claim reserves				21 (2)		
		ncurred claims (add (1) and (2))						
	` '	Claims charged				9b(4)		
	C Rer	nainder of premium: (1) Retention charges (on an accrual basis)		1			
		(A) Commissions		9c(1)(A)				
		(B) Administrative service or other fees		9c(1)(B)				
		(C) Other specific acquisition costs		9c(1)(C)				
		(D) Other expenses		9c(1)(D)				
		(E) Taxes		9c(1)(E)				
		(F) Charges for risks or other contingencies		9c(1)(F)				
		(G) Other retention charges		9c(1)(G)				
		(H) Total retention				9c(1)(H))	
	(2)	Dividends or retroactive rate refunds. (These	e amounts were paid in	cash, or	credited.)	9c(2)		
	d Stat	tus of policyholder reserves at end of year: (I) Amount held to provide	benefits afte	r retirement	9d(1)		
	(2)	Claim reserves				9d(2)		
	(3)	Other reserves				9d(3)		
	e Divi	dends or retroactive rate refunds due. (Do r	ot include amount entere	d in line 9c(2)) .)			
10		perience-rated contracts:		•	,	•		
	a Tota	al premiums or subscription charges paid to	carrier			10a		1
		e carrier, service, or other organization incur						
		ention of the contract or policy, other than rep						
		nature of costs.		-, ·-p			1	
P	art IV	Provision of Information						
11	Did the	insurance company fail to provide any inform	nation necessary to comp	lete Schedule	e A?	Yes	X No	
14	12 If the answer to line 11 is "Yes," specify the information not provided.							

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

File as an attachment to Form 5500.

OMB No. 1210-0110

Pension Benefit Guaranty Corporation Insurance companies are required to provide the inform pursuant to ERISA section 103(a)(2).		rmation	This Fo	orm is Open to Public		
For calendar plan year 20	121 or fiscal plai	<u> </u>	, , , ,	d ending 07/3	1/2022	Inspection
A Name of plan		AND MATERIALS HEALTH A	В -	Three-digit plan number (PN		501
	NSTRUCTION	AND MATERIALS HEALTH AND	O WELFARE FUND	mployer Identifica		
		rning Insurance Contract Individual contracts grouped a				
1 Coverage Information:						
(a) Name of insurance ca	(c) NAIC	(d) Contract or	(e) Approximate number of persons covered at end of	f		contract year
(0,	code	identification number	policy or contract year	(f)	From	(g) To
15-0329043	55107	312000-0001	46	01/01/2021	I	12/31/2021
descending order of the	2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid. (a) Total amount of commissions paid (b) Total amount of fees paid					other persons in
3 Persons receiving com		ees. (Complete as many entries and address of the agent, broker,			were paid	
(b) Amount of sales a			es and other commissions paid			
commissions paid (c) Amount		(c) Amount	(d) Pui	pose		(e) Organization code
	(a) Name a	and address of the agent, broker,	or other person to whom com	missions or fees	were paid	
	,,	.			·	
(b) Amount of sales a	nd hase	Fee	es and other commissions paid			
commissions pa		(c) Amount	(d) Pui	pose		(e) Organization code

Schedule A (Form 5500) 2	2021	Page 2 – 1				
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid						
		Food and other commissions poid	(0)			
(b) Amount of sales and base commissions paid	(c) Amount	Fees and other commissions paid (d) Purpose	(e) Organization code			
())						
(a) Nar	me and address of the agent, broker	r, or other person to whom commissions or fees were paid				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization			
commissions paid	(c) Amount	(d) Purpose	code			
(a) Nar	me and address of the agent, broker	r, or other person to whom commissions or fees were paid				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization			
commissions paid	(c) Amount	(d) Purpose	code			
(a) Nar	me and address of the agent, broker	r, or other person to whom commissions or fees were paid				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization			
commissions paid	(c) Amount	(d) Purpose	code			
(a) Nar	me and address of the agent. broker	r, or other person to whom commissions or fees were paid				
		Fees and other commissions paid	(e)			
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code			

Schedule A (Form 5500) 2021

	Part		idual contracto with cook corrier mou	ha traataa	log a unit for nurnage of
		Where individual contracts are provided, the entire group of such individual this report.	idual contracts with each camer may	De liealec	i as a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end	4	
5	Curr	ent value of plan's interest under this contract in separate accounts at year e	nd	5	
6	Con	tracts With Allocated Funds:			
	а	State the basis of premium rates			
			1		
	b	Premiums paid to carrier		6b	
	C	Premiums due but unpaid at the end of the year		6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount	•	6d	
		Specify nature of costs			
		oposity flature of society			
	е	Type of contract: (1) individual policies (2) group deferred	d annuity		
			a armany		
		(3) other (specify)			
_	<u> </u>	If contract purchased, in whole or in part, to distribute benefits from a termin	<u> </u>		
1		tracts With Unallocated Funds (Do not include portions of these contracts ma			
	а		ate participation guarantee		
		(3) guaranteed investment (4) other			
	b	Balance at the end of the previous year		7b	
	С	Additions: (1) Contributions deposited during the year	7c(1)		
		(2) Dividends and credits	7c(2)		
		(3) Interest credited during the year	7c(3)		
		(4) Transferred from separate account	7c(4) 7c(5)		
		(5) Other (specify below)	70(3)		
		•			
				7 - (0)	
		(6)Total additions		7c(6)	
		Total of balance and additions (add lines 7b and 7c(6))		7d	
	E	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
		(2) Administration charge made by carrier	7e(2)		
		(3) Transferred to separate account	7e(3)		
		(4) Other (specify below)	7e(4)		
		•	- (- /		
		,			
		(E) Total de destace		70/F)	
	£	(5) Total deductions	ı	7e(5) 7f	
	I	Balance at the end of the current year (subtract line 7e(5) from line 7d)		11	

	e same employer(s) or members of the same employee organizations(s), tracts are experience-rated as a unit. Where contracts cover individual arrier may be treated as a unit for purposes of this report.					
8 Benefit and contract type (check all applicable boxes)						
a X Health (other than dental or vision) b ☐ Dental	c ☐ Vision d ☐ Life insurance					
e ☐ Temporary disability (accident and sickness) f ☐ Long-term disabil	ity g Supplemental unemployment h Prescription drug					
i ☐ Stop loss (large deductible) j ☐ HMO contract	k ☐ PPO contract I ☐ Indemnity contract					
m ☐ Other (specify) ▶						
III Ushe (specify)						
9 Experience-rated contracts:						
a Premiums: (1) Amount received	9a(1)					
(2) Increase (decrease) in amount due but unpaid	9a(2)					
(3) Increase (decrease) in unearned premium reserve						
(4) Earned ((1) + (2) - (3))						
b Benefit charges (1) Claims paid	9b(1)					
(2) Increase (decrease) in claim reserves	9b(2)					
(3) Incurred claims (add (1) and (2))	9b(3)					
(4) Claims charged	9b(4)					
c Remainder of premium: (1) Retention charges (on an accrual basis)						
(A) Commissions	9c(1)(A)					
(B) Administrative service or other fees	9c(1)(B)					
(C) Other specific acquisition costs	9c(1)(C)					
(D) Other expenses	9c(1)(D) 9c(1)(E)					
(E) Taxes	9c(1)(F)					
(F) Charges for risks or other contingencies	0 (1)(0)					
(H) Total retention	6 (0)					
(2) Dividends or retroactive rate refunds. (These amounts were paid in	. 🗖					
d Status of policyholder reserves at end of year: (1) Amount held to provide						
(2) Claim reserves						
(3) Other reserves	2 1/2					
Dividends or retroactive rate refunds due. (Do not include amount entere						
10 Nonexperience-rated contracts:						
a Total premiums or subscription charges paid to carrier	10a					
b If the carrier, service, or other organization incurred any specific costs in a retention of the contract or policy, other than reported in Part I, line 2 above Specify nature of costs.	connection with the acquisition or					
Part IV Provision of Information						
11 Did the insurance company fail to provide any information necessary to complete Schedule A?						
12 If the answer to line 11 is "Yes," specify the information not provided.						

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

File as an attachment to Form 5500.

OMB No. 1210-0110

Employee Benefits Security Ad	iriiriistratiori	, , , , , , ,		-			
Pension Benefit Guaranty Co	orporation	•	ompanies are required to provide the information ursuant to ERISA section 103(a)(2).			This Form is Open to Public Inspection	
For calendar plan year 20	21 or fiscal pla	n year beginning 08/01/2021		and ending 07/	31/2022		
A Name of plan			E	3 Three-digit			
ROCHESTER AREA CO	NSTRUCTION	AND MATERIALS HEALTH A		plan number (F	PN) •	501	
				, ,	,		
C Plan sponsor's name a	as shown on lin	e 2a of Form 5500	D	Employer Identifi	cation Number	(EIN)	
ROCHESTER AREA CO	NSTRUCTION	AND MATERIALS HEALTH AND	WELFARE FUND	16-0962644			
		rning Insurance Contract					
1 Coverage Information:		Ţ,		•	•		
(a) Name of insurance ca	arrier						
EXCELLUS HEALTH PLA							
	(0) NIAIO	(4) Continue	(e) Approximate numb	ber of	Policy or co	ontract year	
(b) EIN	(c) NAIC code	(d) Contract or identification number	persons covered at en	nd of) From	(g) To	
15-0329043	55107	17207-0001	13	01/01/202	21	12/31/2021	
2 Insurance fee and com descending order of the		ation. Enter the total fees and total	al commissions paid. List i	in line 3 the agents	, brokers, and o	ther persons in	
(a) Total	amount of com	missions paid		(b) Total amoun	t of fees paid		
3 Persons receiving com		ees. (Complete as many entries					
	(a) Name a	and address of the agent, broker,	or other person to whom o	commissions or fee	s were paid		
(b) Amount of sales a	nd base	Fee	s and other commissions	paid			
commissions pa	iid	(c) Amount	(d)	Purpose		(e) Organization code	
	(a) Name a	and address of the agent, broker,	or other person to whom o	commissions or fee	s were paid		
	\	,					
(b) Amount of sales a	nd base	Fee	s and other commissions	paid			
commissions pa		(c) Amount	(d)	Purpose		(e) Organization code	
						<u> </u>	

Schedule A (Form 5500) 2	2021	Page 2 – 1		
(a) Nar	ne and address of the agent, broker	r, or other person to whom commissions or fees were paid		
	•			
(I) Amount of only and have		Fees and other commissions paid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code	
(a) Nar	ne and address of the agent, broker	r, or other person to whom commissions or fees were paid		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code	
(a) Nar	ne and address of the agent, broker	r, or other person to whom commissions or fees were paid		
			1	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code	
(a) Nar	ne and address of the agent, broker	r, or other person to whom commissions or fees were paid		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code	
(a) Nar	ne and address of the agent, broker	r, or other person to whom commissions or fees were paid		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code	

Schedule A (Form 5500) 2021

Part II		Investment and Annuity Contract Information					
		Where individual contracts are provided, the entire group of such indivi	dual contracts with each carrier ma	y be treated	as a unit for purposes of		
4	Curr	this report. ent value of plan's interest under this contract in the general account at year of the second	and	4			
		ent value of plan's interest under this contract in the general accounts at year er		5			
		racts With Allocated Funds:					
Ū	a	State the basis of premium rates					
	_	Clate the same of promisin rates					
	b	Premiums paid to carrier		6b			
	С	Premiums due but unpaid at the end of the year		6c			
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount		6d			
		Specify nature of costs					
	е	Type of contract: (1) ☐ individual policies (2) ☐ group deferred	d annuity				
		(3) other (specify)					
		(e) [] cance (ep con))					
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, check here				
7		racts With Unallocated Funds (Do not include portions of these contracts mai	<u> </u>				
•			te participation guarantee				
	а		te participation guarantee				
		(3) guaranteed investment (4) dother					
	L			71.			
	b	Balance at the end of the previous year		7b			
	С	Additions: (1) Contributions deposited during the year	7c(1) 7c(2)				
		(2) Dividends and credits	7c(3)				
		(4) Transferred from separate account	7c(4)				
		(5) Other (specify below)	7c(5)				
		b	13(3)				
		<i>'</i>					
		(O)T + 1 - 1 PC		70(6)			
	4	(6)Total additions		7c(6) 7d			
		Total of balance and additions (add lines 7b and 7c(6)) Deductions:		74			
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)				
		(2) Administration charge made by carrier	7e(2)				
		(3) Transferred to separate account	7e(3)				
		(4) Other (specify below)	7e(4)				
		b					
		,					
				7o/5\			
	_	(5) Total deductions		7e(5)			
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)		7 f			

Part III Welfare Benefit Contract Information If more than one contract covers the same group of employees of	the same employer(s) or members of the same employee organizations(s), ontracts are experience-rated as a unit. Where contracts cover individual
employees, the entire group of such individual contracts with each	
Benefit and contract type (check all applicable boxes)	
a ☐ Health (other than dental or vision) b ☐ Dental	c ☐ Vision d ☐ Life insurance
e ☐ Temporary disability (accident and sickness) f ☐ Long-term disa	bility g Supplemental unemployment h Prescription drug
i Stop loss (large deductible) j HMO contract	k ☐ PPO contract I ☐ Indemnity contract
m Other (specify)	_
9 Experience-rated contracts:	
a Premiums: (1) Amount received	9a(1)
(2) Increase (decrease) in amount due but unpaid	
(3) Increase (decrease) in unearned premium reserve	9a(3)
(4) Earned ((1) + (2) - (3))	9a(4)
b Benefit charges (1) Claims paid	·
(2) Increase (decrease) in claim reserves	9b(2)
(3) Incurred claims (add (1) and (2))	
(4) Claims charged	
C Remainder of premium: (1) Retention charges (on an accrual basis)	
(A) Commissions	9c(1)(A)
(B) Administrative service or other fees	
(C) Other specific acquisition costs	
(D) Other expenses	0.4440
(E) Taxes	0-(4)(5)
(F) Charges for risks or other contingencies	0 (4)(=)
(G) Other retention charges	0.747/07
(H) Total retention	0.4040
(2) Dividends or retroactive rate refunds. (These amounts were paid	
<u> </u>	
d Status of policyholder reserves at end of year: (1) Amount held to provi	
(2) Claim reserves	
(3) Other reserves	
Dividends or retroactive rate refunds due. (Do not include amount enter	red in line 9c(2).) 9e
10 Nonexperience-rated contracts:	40-
Total premiums or subscription charges paid to carrier	
b If the carrier, service, or other organization incurred any specific costs i	
retention of the contract or policy, other than reported in Part I, line 2 at Specify nature of costs.	pove, report amount
Specify flature of costs.	
Part IV Provision of Information	
11 Did the insurance company fail to provide any information necessary to con	nplete Schedule A? Yes X No
12 If the answer to line 11 is "Yes," specify the information not provided.	

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

File as an attachment to Form 5500.

OMB No. 1210-0110

Employee Benefits Security Ad	IIIIIIStration	, ino ao an a		·.					
Pension Benefit Guaranty Co	orporation	•	Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).			This Form is Open to Public Inspection			
For calendar plan year 20	21 or fiscal pla	n year beginning 08/01/2021		and end	ding 07/3	1/2022			
A Name of plan				B Three	e-digit				
ROCHESTER AREA CO	NSTRUCTION	AND MATERIALS HEALTH A			number (PN	1) •	501		
					, , ,	,	1		
C Plan sponsor's name a	as shown on lin	e 2a of Form 5500		D Employ	ver Identifica	ation Number	(EIN)		
·		AND MATERIALS HEALTH AND			0962644		,		
	Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.								
1 Coverage Information:		<u> </u>		•					
(a) Name of insurance ca	arrier								
	(c) NAIC	(d) Contract or	(e) Approximate nur	mber of		Policy or c	ontract year		
(b) EIN	code	identification number	persons covered at policy or contract		(f)	From	(g) To		
81-1242192	55107	RCM 5830001	21		01/01/2021	1	12/31/2021		
2 Insurance fee and com descending order of the		ation. Enter the total fees and tota	al commissions paid. Lis	st in line 3 t	the agents, l	brokers, and o	ther persons in		
(a) Total	amount of com	missions paid		(b) To	tal amount o	of fees paid			
3 Persons receiving com		ees. (Complete as many entries and address of the agent, broker,			one or fees	were naid			
(b) Amount of sales a		•	es and other commissions			·			
commissions pa		(c) Amount		(d) Purpose			(e) Organization code		
	(a) r suppose								
	(a) Name a	and address of the agent, broker,	or other person to whom	commissi	ons or fees	were paid			
(b) Amount of sales a	nd base	Fee	es and other commissions	s paid					
commissions pa		(c) Amount		d) Purpose)		(e) Organization code		
55		1-1,		,,			(3) 0.3020.01		
							<u> </u>		

Schedule A (Form 5500) 2	2021	Page 2 – 1				
(a) Nar	me and address of the agent, broker	r, or other person to whom commissions or fees were paid				
		Food and other commissions poid	(0)			
(b) Amount of sales and base commissions paid	(c) Amount	Fees and other commissions paid (d) Purpose	(e) Organization code			
())						
(a) Nar	me and address of the agent, broker	r, or other person to whom commissions or fees were paid				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization			
commissions paid	(c) Amount	(d) Purpose	code			
(a) Nar	me and address of the agent, broker	r, or other person to whom commissions or fees were paid				
			(e)			
(b) Amount of sales and base	Fees and other commissions paid					
commissions paid	(c) Amount	(d) Purpose	Organization code			
(a) Nar	me and address of the agent, broker	r, or other person to whom commissions or fees were paid				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization			
commissions paid	(c) Amount	(d) Purpose	code			
(a) Nar	me and address of the agent. broker	r, or other person to whom commissions or fees were paid				
	Fees and other commissions paid					
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code			

Schedule A (Form 5500) 2021

	Part		idual contracto with cook corrier mou	ha traataa	log a unit for nurnage of
		Where individual contracts are provided, the entire group of such individual this report.	idual contracts with each camer may	De liealec	i as a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end	4	
5	Curr	ent value of plan's interest under this contract in separate accounts at year e	nd	5	
6	Con	tracts With Allocated Funds:			
	а	State the basis of premium rates			
			1		
	b	Premiums paid to carrier		6b	
	C	Premiums due but unpaid at the end of the year		6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount	•	6d	
		Specify nature of costs			
		oposity flature of society			
	е	Type of contract: (1) individual policies (2) group deferred	d annuity		
			a armany		
		(3) other (specify)			
_	<u> </u>	If contract purchased, in whole or in part, to distribute benefits from a termin	<u> </u>		
1		tracts With Unallocated Funds (Do not include portions of these contracts ma			
	а		ate participation guarantee		
		(3) guaranteed investment (4) other			
	b	Balance at the end of the previous year		7b	
	С	Additions: (1) Contributions deposited during the year	7c(1)		
		(2) Dividends and credits	7c(2)		
		(3) Interest credited during the year	7c(3)		
		(4) Transferred from separate account	7c(4) 7c(5)		
		(5) Other (specify below)	70(3)		
		•			
				7 - (0)	
		(6)Total additions		7c(6)	
		Total of balance and additions (add lines 7b and 7c(6))		7d	
	E	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
		(2) Administration charge made by carrier	7e(2)		
		(3) Transferred to separate account	7e(3)		
		(4) Other (specify below)	7e(4)		
		•	- (- /		
		,			
		(E) Total de destace		70/F)	
	£	(5) Total deductions	ı	7e(5) 7f	
	I	Balance at the end of the current year (subtract line 7e(5) from line 7d)		11	

Pa	Welfare Benefit Contract Information If more than one contract covers the same group of employees of	of the same employe	er(s) or members of the same e	employee organizations(s),
	the information may be combined for reporting purposes if such	contracts are experi	ence-rated as a unit. Where c	ontracts cover individual
	employees, the entire group of such individual contracts with each	ch carrier may be tre	eated as a unit for purposes of	this report.
8 B	Benefit and contract type (check all applicable boxes)			
a	a ⊠ Health (other than dental or vision) b □ Dental	c 🗌 🗸	Vision	d Life insurance
e	e \square Temporary disability (accident and sickness) f \square Long-term dis	ability g S	Supplemental unemployment	h Prescription drug
i	i Stop loss (large deductible) j HMO contract	k	PPO contract	I Indemnity contract
r	m ☐ Other (specify) ▶			
9 F	Experience-rated contracts:			
	a Premiums: (1) Amount received	9a(1)		
·	` '			
	(2) Increase (decrease) in amount due but unpaid			_
	(3) Increase (decrease) in unearned premium reserve			
	(4) Earned ((1) + (2) - (3))		9a(4)	
	b Benefit charges (1) Claims paid			
	(2) Increase (decrease) in claim reserves	9b(2)		
	(3) Incurred claims (add (1) and (2))		9b(3)	
	(4) Claims charged		9b(4)	
(C Remainder of premium: (1) Retention charges (on an accrual basis)	•		
	(A) Commissions	9c(1)(A)		
	(B) Administrative service or other fees			
	(C) Other specific acquisition costs			
	(D) Other expenses	0 (4)(D)		
	(E) Taxes	0-(4)(5)		_
	` '	0 (4)(=)		
	(F) Charges for risks or other contingencies	0 (4)(0)		
	(G) Other retention charges		0=(4)(11	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \
	(H) Total retention)
	(2) Dividends or retroactive rate refunds. (These amounts were page 2)	aid in cash, or	edited.) 9c(2)	
(d Status of policyholder reserves at end of year: (1) Amount held to prov	vide benefits after re	etirement 9d(1)	
	(2) Claim reserves		9d(2)	
	(3) Other reserves		9d(3)	
(e Dividends or retroactive rate refunds due. (Do not include amount ent	tered in line 9c(2).)	9e	
10	Nonexperience-rated contracts:	```	-	
	a Total premiums or subscription charges paid to carrier		10a	
	b If the carrier, service, or other organization incurred any specific costs retention of the contract or policy, other than reported in Part I, line 2 a			
S	Specify nature of costs.	above, report amour	100	
Pai	art IV Provision of Information			
			о П Vaa	X No
	Did the insurance company fail to provide any information necessary to co	omplete Schedule A	? Yes	NO NIO
12	If the answer to line 11 is "Yes," specify the information not provided.			

Department of the Treasury Internal Revenue Service

Department of Labor

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

File as an attachment to Form 5500.

OMB No. 1210-0110

Employee Benefits Security Ad	ministration	F File as all a	ttacilile it to Form 55	00.			
Pension Benefit Guaranty Corporation Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).				This Form is Open to Public Inspection			
For calendar plan year 20	21 or fiscal pla	n year beginning 08/01/2021		and en	ding 07/3	1/2022	
A Name of plan ROCHESTER AREA CO	NSTRUCTION	AND MATERIALS HEALTH A			e-digit number (PN	1) 🕨	501
C Plan sponsor's name a		e 2a of Form 5500 AND MATERIALS HEALTH AND) WELFARE FUND		yer Identifica 0962644	ation Numb	ber (EIN)
		rning Insurance Contract Lindividual contracts grouped as					
1 Coverage Information:							
(a) Name of insurance ca	N T	Т	(e) Approximate nu	ımber of		Policy	or contract year
(b) EIN	(c) NAIC code	(d) Contract or identification number	persons covered a policy or contract	t end of	(f)	From	(g) To
15-0329043	55107	34065-0001	10	•	01/01/2021	1	12/31/2021
2 Insurance fee and com descending order of the		ation. Enter the total fees and total	al commissions paid. Li	ist in line 3	the agents, I	brokers, ar	nd other persons in
(a) Total	amount of com	missions paid		(b) To	otal amount o	of fees paid	d
3 Persons receiving com	missions and f	ees. (Complete as many entries	as needed to report all	persons).			
	(a) Name a	and address of the agent, broker,	or other person to whor	m commiss	ions or fees	were paid	
		Foo	s and other commission	oo poid			
(b) Amount of sales a							(2) Oznaziration anda
commissions pa	id	(c) Amount		(d) Purpos	.		(e) Organization code
	(a) Name a	and address of the agent, broker,	or other person to whor	m commiss	ions or fees	were paid	
			·			•	
(b) Amount of sales a	nd hase	Fee	s and other commissior	ns paid			
commissions pa		(c) Amount	((d) Purpos	e		(e) Organization code
For Post of the Control of the Contr	m Ant Note:	and the Instructions for Form F	500				phodulo A (Form FF00) 2021

Schedule A (Form 5500) 2021 Page 2 – 1							
(a) Nar	me and address of the agent, broke	er, or other person to whom commissions or fees were paid					
#NA		Fees and other commissions paid	(e)				
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code				
(a) Nar	me and address of the agent, broke	er, or other person to whom commissions or fees were paid					
		Fees and other commissions paid	(e)				
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code				
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid							
#NA	Fees and other commissions paid						
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code				
(a) Nar	me and address of the agent, broke	er, or other person to whom commissions or fees were paid					
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization				
commissions paid	(c) Amount	(d) Purpose	code				
(a) Nar	me and address of the agent, broke	er, or other person to whom commissions or fees were paid					
(b) Amount of color and hass		Fees and other commissions paid	(e)				
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code				

Schedule A (Form 5500) 2021

	Part		idual contracto with cook corrier mou	ha traataa	log a unit for nurnage of
		Where individual contracts are provided, the entire group of such individual this report.	idual contracts with each camer may	De liealec	i as a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end	4	
5	Curr	ent value of plan's interest under this contract in separate accounts at year e	nd	5	
6	Con	tracts With Allocated Funds:			
	а	State the basis of premium rates			
			1		
	b	Premiums paid to carrier		6b	
	C	Premiums due but unpaid at the end of the year		6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount	•	6d	
		Specify nature of costs			
		oposity flature of society			
	е	Type of contract: (1) individual policies (2) group deferred	d annuity		
			a armany		
		(3) other (specify)			
_	<u> </u>	If contract purchased, in whole or in part, to distribute benefits from a termin	<u> </u>		
1		tracts With Unallocated Funds (Do not include portions of these contracts ma			
	а		ate participation guarantee		
		(3) guaranteed investment (4) other			
	b	Balance at the end of the previous year		7b	
	С	Additions: (1) Contributions deposited during the year	7c(1)		
		(2) Dividends and credits	7c(2)		
		(3) Interest credited during the year	7c(3)		
		(4) Transferred from separate account	7c(4) 7c(5)		
		(5) Other (specify below)	70(3)		
		•			
				7 - (0)	
		(6)Total additions		7c(6)	
		Total of balance and additions (add lines 7b and 7c(6))		7d	
	E	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
		(2) Administration charge made by carrier	7e(2)		
		(3) Transferred to separate account	7e(3)		
		(4) Other (specify below)	7e(4)		
		•	- (- /		
		,			
		(E) Total de destace		70/F)	
	£	(5) Total deductions	ı	7e(5) 7f	
	I	Balance at the end of the current year (subtract line 7e(5) from line 7d)		11	

	T						
Part III	Welfare Benefit Contract Inform If more than one contract covers the same		ne same er	mplo	yer(s) or members of	the same e	mployee organizations(s).
	the information may be combined for repor						
	employees, the entire group of such individ	lual contracts with each of	carrier may	be t	reated as a unit for p	ourposes of the	his report.
8 Benefit	and contract type (check all applicable boxes)	1					
a X ⊦	lealth (other than dental or vision)	b Dental		С	Vision		d Life insurance
е 🗌 т	emporary disability (accident and sickness)	f Long-term disabil	lity	g 🗌	Supplemental unem	ployment	h Prescription drug
i 🗌 s	top loss (large deductible)	j HMO contract		k 🗌	PPO contract		I Indemnity contract
m∏d	Other (specify)						
Ш	(1						
9 Experier	nce-rated contracts:						
•	niums: (1) Amount received		9a(1)				
	Increase (decrease) in amount due but unpai		9a(2)				
	Increase (decrease) in unearned premium res						_
` ,	Earned ((1) + (2) - (3))					. 9a(4)	
_	nefit charges (1) Claims paid					., Ju(+)	
	• • • •		/				
` '	Increase (decrease) in claim reserves					0b/2)	
` ,	Incurred claims (add (1) and (2))					9b(3)	+
` '	Claims charged(1) Betational and a		•••••			9b(4)	
C Re	mainder of premium: (1) Retention charges (c	,	0-(4)//	• • •			_
	(A) Commissions		9c(1)(A				_
	(B) Administrative service or other fees		9c(1)(E				_
	(C) Other specific acquisition costs		9c(1)(0				_
	(D) Other expenses		9c(1)([_
	(E) Taxes		9c(1)(E	_			
	(F) Charges for risks or other contingencies		- ////				
	(G) Other retention charges					2 (4)(1)	
	(H) Total retention	_		_		9c(1)(H)	
(2)	Dividends or retroactive rate refunds. (These	e amounts were 📗 paid i	n cash, or	С	redited.)	9c(2)	
d Sta	atus of policyholder reserves at end of year: (1	I) Amount held to provide	benefits a	after	retirement	9d(1)	
(2)	Claim reserves					9d(2)	
(3)	Other reserves					9d(3)	
e Div	ridends or retroactive rate refunds due. (Do n	ot include amount entere	ed in line 9	c(2).)	9e	
10 Nonex	perience-rated contracts:						
a To	tal premiums or subscription charges paid to	carrier				10a	1
b If t	ne carrier, service, or other organization incur	red any specific costs in	connection	n with	the acquisition or		
	ention of the contract or policy, other than rep					10b	
	nature of costs.						•
Part IV	Provision of Information						
						V	V Na
	e insurance company fail to provide any inforn		olete Sche	dule	A?	Yes	X No
12 If the a	inswer to line 11 is "Yes," specify the informat	ion not provided.					

SCHEDULE A (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

File as an attachment to Form 5500.

OMB No. 1210-0110

Employee Benefits Security Ac	dministration	y rile as all a	ttacilile it to Form 55	00.			
Pension Benefit Guaranty Corporation Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).			This	This Form is Open to Public Inspection			
For calendar plan year 20	21 or fiscal pla	n year beginning 08/01/2021		and en	ding 07/3	1/2022	
A Name of plan ROCHESTER AREA CO	NSTRUCTION	AND MATERIALS HEALTH A			e-digit number (PN	1) 🕨	501
	NSTRUCTION	AND MATERIALS HEALTH AND		16-	yer Identifica 0962644		
		rning Insurance Contract Lindividual contracts grouped as					
1 Coverage Information:							
(a) Name of insurance ca		(d) Contract or	(e) Approximate nu			Policy (or contract year
(b) EIN	code	identification number	persons covered a policy or contract		(f)	From	(g) To
14-1640868	95521	706308-0001	118	. ,	01/01/2021	1	12/31/2021
2 Insurance fee and com descending order of the		ation. Enter the total fees and total	al commissions paid. Li	st in line 3	the agents,	brokers, ar	nd other persons in
(a) Total amount of commissions paid (b) Total amount of fees paid						d	
3 Persons receiving com		ees. (Complete as many entries					
(b) Amount of sales a commissions pa	nd base	Fee (c) Amount	s and other commission			word pala	(e) Organization code
	(a) Name a	and address of the agent, broker,	or other person to whor	n commiss	ions or fees	were paid	
	(a) Hamo	and agong broker,	5. 5.1.6. po. 50/1 to WHO!	55.7111105	.5710 01 1000	paid	
(b) Amount of sales and base Fees and other commissions paid							
commissions pa		(c) Amount		(d) Purpos	e		(e) Organization code
For Donomically Dodinatio	n Ant Nation	and the Instructions for Form F	500			0.	phodulo A (Form 5500) 2021

Schedule A (Form 5500) 2	2021	Page 2 – 1	
(a) Nar	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
(u) Hai	The and address of the agent, broken	, or other person to whom commissions or rece were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base	(c) Amount	(d) Purpose	Organization
commissions paid	(b) / tillodin	(a) i dipose	code
(a) Nar	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Nar	me and address of the agent, broker.	r, or other person to whom commissions or fees were paid	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Nar	ne and address of the agent, broker	, or other person to whom commissions or fees were paid	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Nar	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
	,		
(1) A		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code

Schedule A (Form 5500) 2021

	Part		idual contracto with cook corrier mou	ha traataa	log a unit for nurnage of
		Where individual contracts are provided, the entire group of such individual this report.	idual contracts with each camer may	De liealec	ras a unit for purposes or
4	Curr	ent value of plan's interest under this contract in the general account at year	end	4	
5	Curr	ent value of plan's interest under this contract in separate accounts at year e	nd	5	
6	Con	tracts With Allocated Funds:			
	а	State the basis of premium rates			
			1		
	b	Premiums paid to carrier		6b	
	C	Premiums due but unpaid at the end of the year		6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount	•	6d	
		Specify nature of costs			
		oposity flature of society			
	е	Type of contract: (1) individual policies (2) group deferred	d annuity		
			a armany		
		(3) other (specify)			
_	<u> </u>	If contract purchased, in whole or in part, to distribute benefits from a termin	<u> </u>		
1		tracts With Unallocated Funds (Do not include portions of these contracts ma			
	а		ate participation guarantee		
		(3) guaranteed investment (4) other			
	b	Balance at the end of the previous year		7b	
	С	Additions: (1) Contributions deposited during the year	7c(1)		
		(2) Dividends and credits	7c(2)		
		(3) Interest credited during the year	7c(3)		
		(4) Transferred from separate account	7c(4) 7c(5)		
		(5) Other (specify below)	70(3)		
		•			
				7 - (0)	
		(6)Total additions		7c(6)	
		Total of balance and additions (add lines 7b and 7c(6))		7d	
	E	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
		(2) Administration charge made by carrier	7e(2)		
		(3) Transferred to separate account	7e(3)		
		(4) Other (specify below)	7e(4)		
		•	- (- /		
		,			
		(E) Total de destace		70/F)	
	£	(5) Total deductions	ı	7e(5) 7f	
	I	Balance at the end of the current year (subtract line 7e(5) from line 7d)		11	

Part III Welfare Benefit Contract Information If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.					
8 Benefit and contract type (check all applicable boxes)					
a X Health (other than dental or vision) b ☐ Dental	c				
e ☐ Temporary disability (accident and sickness) f ☐ Long-term disabil	ity g Supplemental unemployment h Prescription drug				
i ☐ Stop loss (large deductible) j ☐ HMO contract	k PPO contract				
	R 110 contract				
m ☐ Other (specify) ▶					
O Firm original and another state					
9 Experience-rated contracts:	00(1)				
a Premiums: (1) Amount received	9a(1) 1 9a(2)				
(2) Increase (decrease) in amount due but unpaid					
(4) Earned ((1) + (2) - (3))					
b Benefit charges (1) Claims paid	, i				
(2) Increase (decrease) in claim reserves	21 (2)				
(3) Incurred claims (add (1) and (2))					
(4) Claims charged	21.10				
C Remainder of premium: (1) Retention charges (on an accrual basis)					
(A) Commissions	9c(1)(A)				
(B) Administrative service or other fees	9c(1)(B)				
(C) Other specific acquisition costs	9c(1)(C)				
(D) Other expenses	9c(1)(D)				
(E) Taxes	9c(1)(E)				
(F) Charges for risks or other contingencies	9c(1)(F)				
(G) Other retention charges					
(H) Total retention	<u> </u>				
(2) Dividends or retroactive rate refunds. (These amounts were paid i	n cash, or credited.) 9c(2)				
d Status of policyholder reserves at end of year: (1) Amount held to provide	benefits after retirement				
(2) Claim reserves					
(3) Other reserves					
e Dividends or retroactive rate refunds due. (Do not include amount entere	d in line 9c(2).)				
10 Nonexperience-rated contracts:					
a Total premiums or subscription charges paid to carrier	10a				
b If the carrier, service, or other organization incurred any specific costs in a retention of the contract or policy, other than reported in Part I, line 2 above Specify nature of costs.	401				
Part IV Provision of Information					
Part IV Provision of Information					
11 Did the insurance company fail to provide any information necessary to comp	lete Schedule A? Yes X No				
12 If the answer to line 11 is "Yes," specify the information not provided.					

SCHEDULE A (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

OMB No. 1210-0110

Employee Benefits Security Ad	ministration	File as an a	ttachment to Form 55	00.			
Pension Benefit Guaranty Corporation Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).			This Form is Open to Public Inspection				
For calendar plan year 20	21 or fiscal plar	n year beginning 08/01/2021		and ending 07/31/2022			
A Name of plan ROCHESTER AREA CO	NSTRUCTION	AND MATERIALS HEALTH A			e-digit number (PN	N) •	501
C Plan sponsor's name a ROCHESTER AREA CO		e 2a of Form 5500 AND MATERIALS HEALTH AND) WELFARE FUND	•	yer Identifica 0962644	ation Numbe	r (EIN)
		rning Insurance Contract . Individual contracts grouped as					
1 Coverage Information:							
(a) Name of insurance ca)					
(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate nu persons covered a policy or contract	t end of	(f)	Policy or From	contract year (g) To
15-0329043	55107	6457	71	. ,	01/01/2021	1	12/31/2021
2 Insurance fee and com descending order of the		ation. Enter the total fees and tota	al commissions paid. Li	st in line 3	the agents, l	brokers, and	other persons in
(a) Total amount of commissions paid (b) Total amount of fees paid							
		33904					
3 Persons receiving com	missions and fe	ees. (Complete as many entries	as needed to report all	persons).			
<u> </u>		and address of the agent, broker,			ions or fees	were paid	
LOUIS ARGIRO			RLINGTON ROAD CUSE, NY 13208				
(b) Amount of sales a	nd hase	Fee	s and other commission	ns paid			
commissions pa		(c) Amount		(d) Purpose			(e) Organization code
	33904						3
	(a) Name a	and address of the agent, broker,	or other person to whor	n commiss	ions or fees	were paid	
(b) Amount of sales a	nd base	Fee	s and other commissior	ns paid	<u> </u>		
commissions pa		(c) Amount		(d) Purpose	9		(e) Organization code
For Panerwork Reduction	n Act Notice	see the Instructions for Form 5	500			Sch	edule A (Form 5500) 2021

Schedule A (Form 5500) 2	2021	Page 2 – 1	
(a) Nar	me and address of the agent, broke	er, or other person to whom commissions or fees were paid	
· ·	· ·		
		Fees and other commissions paid	(e)
(b) Amount of sales and base	(c) Amount	(d) Purpose	Organization
commissions paid	(O) / Willout	(a) i dipose	code
(a) Nar	me and address of the agent, broke	er, or other person to whom commissions or fees were paid	
	-		
		Fees and other commissions paid	(e)
(b) Amount of sales and base	(c) Amount	(d) Purpose	Organization
commissions paid	(c) Amount	(d) i dipose	code
(a) Nar	me and address of the agent, broke	er, or other person to whom commissions or fees were paid	
, ,	,	,	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Nar	me and address of the agent, broke	er, or other person to whom commissions or fees were paid	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Nar	me and address of the agent, broke	er, or other person to whom commissions or fees were paid	
	Г		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code

Schedule A (Form 5500) 2021

F	Part				
		Where individual contracts are provided, the entire group of such indivi	dual contracts with	n each carrier may be tre	ated as a unit for purposes of
1	Curr	this report. ent value of plan's interest under this contract in the general account at year.	end	4	
		ent value of plan's interest under this contract in the general accounts at year e			
_		racts With Allocated Funds:		<u>_</u>	
Ŭ	a	State the basis of premium rates			
	_	Clate the basic of promisin rates y			
	b	Premiums paid to carrier		6b	<u> </u>
	С	Premiums due but unpaid at the end of the year		_	
	d	If the carrier, service, or other organization incurred any specific costs in cor	nnection with the a	cquisition or 60	1
		retention of the contract or policy, enter amount			<u>'</u>
		Specify nature of costs			
	е	Type of contract: (1) individual policies (2) group deferred	d annuity		
		(3) other (specify)			
		_			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, check h	nere 🕨 🗌	
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in separat	e accounts)	
	а		te participation gu		
		(3) guaranteed investment (4) other			
		(b) [] guaranteed investment (1) [] ether y			
	b	Balance at the end of the previous year			, [
	c	Additions: (1) Contributions deposited during the year	7c(1)		
	_	(2) Dividends and credits	7c(2)		
		(3) Interest credited during the year	7c(3)		
		(4) Transferred from separate account	7c(4)		
		(5) Other (specify below)	7c(5)		
		>			
		(6)Total additions		7c(6)
	d	Total of balance and additions (add lines 7b and 7c(6)).			
	е	Deductions:			
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
		(2) Administration charge made by carrier	7e(2)		
		(3) Transferred to separate account	7e(3)		
		(4) Other (specify below)	7e(4)		
		•			
		(5) Total deductions		7e(5)
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			

	he same employer(s) or members of the same employee organizations(s), ntracts are experience-rated as a unit. Where contracts cover individual carrier may be treated as a unit for purposes of this report.				
8 Benefit and contract type (check all applicable boxes)					
a X Health (other than dental or vision) b ☐ Dental	c ☐ Vision d ☐ Life insurance				
e ☐ Temporary disability (accident and sickness) f ☐ Long-term disabi					
i Stop loss (large deductible) j HMO contract	k ☐ PPO contract I ☐ Indemnity contract				
m ☐ Other (specify) ▶					
9 Experience-rated contracts:					
a Premiums: (1) Amount received					
(2) Increase (decrease) in amount due but unpaid					
(3) Increase (decrease) in unearned premium reserve	9a(3)				
(4) Earned ((1) + (2) - (3))					
b Benefit charges (1) Claims paid					
(2) Increase (decrease) in claim reserves	9b(2)				
(3) Incurred claims (add (1) and (2))	` '				
(4) Claims charged	9b(4)				
c Remainder of premium: (1) Retention charges (on an accrual basis)					
(A) Commissions	9c(1)(A)				
(B) Administrative service or other fees					
(C) Other specific acquisition costs					
(D) Other expenses					
(E) Taxes					
(F) Charges for risks or other contingencies					
(G) Other retention charges	9c(1)(G)				
(H) Total retention	9c(1)(H)				
(2) Dividends or retroactive rate refunds. (These amounts were paid	in cash, or credited.)				
d Status of policyholder reserves at end of year: (1) Amount held to provide					
(2) Claim reserves	· · · · · ·				
(3) Other reserves					
e Dividends or retroactive rate refunds due. (Do not include amount entere					
10 Nonexperience-rated contracts:					
a Total premiums or subscription charges paid to carrier	10a 1				
b If the carrier, service, or other organization incurred any specific costs in retention of the contract or policy, other than reported in Part I, line 2 about 1 in the contract or policy, other than reported in Part I, line 2 about 1 in the contract or policy.	connection with the acquisition or				
Specify nature of costs.					
Part IV Provision of Information					
11 Did the insurance company fail to provide any information necessary to com	plete Schedule A? Yes X No				
12 If the answer to line 11 is "Yes," specify the information not provided.					

SCHEDULE A (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

File as an attachment to Form 5500.

OMB No. 1210-0110

Employee Benefits Security Ac	ministration	F File as all a	ttacimient to Form 55	00.				
Pension Benefit Guaranty Corporation Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).			This	This Form is Open to Public Inspection				
For calendar plan year 20	21 or fiscal pla	n year beginning 08/01/2021		and en	ding 07/3	1/2022		
A Name of plan ROCHESTER AREA CO	NSTRUCTION	I AND MATERIALS HEALTH A			e-digit number (PN	J) •		501
C Plan sponsor's name a		e 2a of Form 5500 AND MATERIALS HEALTH AND	WELFARE FUND		oyer Identifica 0962644	ation Num	ber (E	EIN)
		rning Insurance Contract A. Individual contracts grouped as						
1 Coverage Information:								
(a) Name of insurance ca		F						
	(c) NAIC	(d) Contract or	(e) Approximate nu	ımber of		Policy	or co	ntract year
(b) EIN	code	identification number	persons covered a policy or contract		(f)	From		(g) To
15-0329043	55107	100221	1		01/01/2021	1		12/31/2021
2 Insurance fee and com descending order of the		ation. Enter the total fees and total	al commissions paid. Li	st in line 3	the agents,	brokers, a	nd oth	her persons in
(a) Total	amount of com	missions paid		(b) To	otal amount	of fees pai	d	
3 Persons receiving com	missions and f	rees. (Complete as many entries	as needed to report all	persons).				
		and address of the agent, broker,			ions or fees	were paid		
	Ţ							
(b) Amount of sales a	nd base		s and other commission					
commissions pa	nid	(c) Amount		(d) Purpos	e			(e) Organization code
	(a) Name :	and address of the agent, broker,	or other person to whor	m commiss	ions or fees	were naid		
	(a) Hamo	and address of the agent, proton,	or early percent to micr	<u> </u>	10110 01 1000	woro para		
(b) Amount of sales a	nd base	Fee	s and other commission	ns paid				_
commissions pa		(c) Amount		(d) Purpos	е			(e) Organization code
For Dononwork Bodustie	n Act Notice	see the Instructions for Form F	500			0	ممم	ulo A (Form 5500) 2021

Schedule A (Form 5500) 2	2021	Page 2 – 1	
(a) Nai	me and address of the agent, broke	r, or other person to whom commissions or fees were paid	
		From and other conscious and	(-)
(b) Amount of sales and base	(a) A == a == t	Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Nai	me and address of the agent, broke	r, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
commissions para			0000
(a) No.	ma and address of the agent broke	ar ather person to whom commissions or feed were noid	
(a) Nai	The and address of the agent, broke	r, or other person to whom commissions or fees were paid	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Nai	me and address of the agent, broke	r, or other person to whom commissions or fees were paid	
			(-)
(b) Amount of sales and base	(c) Amount	Fees and other commissions paid (d) Purpose	(e) Organization
commissions paid	(c) Amount	(u) i dipose	code
(a) Nai	me and address of the agent, broke	r, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
,			

Schedule A (Form 5500) 2021

	Part		idual contracto with cook corrier mou	ha traataa	log a unit for nurnage of
		Where individual contracts are provided, the entire group of such individual this report.	idual contracts with each camer may	De liealec	ras a unit for purposes or
4	Curr	ent value of plan's interest under this contract in the general account at year	end	4	
5	Curr	ent value of plan's interest under this contract in separate accounts at year e	nd	5	
6	Con	tracts With Allocated Funds:			
	а	State the basis of premium rates			
			1		
	b	Premiums paid to carrier		6b	
	C	Premiums due but unpaid at the end of the year		6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount	•	6d	
		Specify nature of costs			
		oposity flature of society			
	е	Type of contract: (1) individual policies (2) group deferred	d annuity		
			a armany		
		(3) other (specify)			
_	<u> </u>	If contract purchased, in whole or in part, to distribute benefits from a termin	<u> </u>		
1		tracts With Unallocated Funds (Do not include portions of these contracts ma			
	а		ate participation guarantee		
		(3) guaranteed investment (4) other			
	b	Balance at the end of the previous year		7b	
	С	Additions: (1) Contributions deposited during the year	7c(1)		
		(2) Dividends and credits	7c(2)		
		(3) Interest credited during the year	7c(3)		
		(4) Transferred from separate account	7c(4) 7c(5)		
		(5) Other (specify below)	70(3)		
		•			
				7 - (0)	
		(6)Total additions		7c(6)	
		Total of balance and additions (add lines 7b and 7c(6))		7d	
	E	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
		(2) Administration charge made by carrier	7e(2)		
		(3) Transferred to separate account	7e(3)		
		(4) Other (specify below)	7e(4)		
		•	- (- /		
		,			
		(E) Total de destace		70/F)	
	£	(5) Total deductions	ı	7e(5) 7f	
	I	Balance at the end of the current year (subtract line 7e(5) from line 7d)		11	

Part III Welfare Benefit Contract Information If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual						
employees, the entire group of such individual contracts with each ca						
Benefit and contract type (check all applicable boxes)			·			
a X Health (other than dental or vision) b X Dental	с□	Vision	d Life insurance			
e ☐ Temporary disability (accident and sickness) f ☐ Long-term disability	느	Supplemental unemployment	블			
			=			
i Stop loss (large deductible) j HMO contract	k∐	PPO contract	I Indemnity contract			
m ☐ Other (specify) ▶						
0.5						
9 Experience-rated contracts:	0-(4)					
a Premiums: (1) Amount received	9a(1)					
(2) Increase (decrease) in amount due but unpaid	9a(2) 9a(3)					
(4) Earned ((1) + (2) - (3))		9a(4	N .			
b Benefit charges (1) Claims paid						
(2) Increase (decrease) in claim reserves	21 (2)					
(3) Incurred claims (add (1) and (2))		9b(3	3)			
(4) Claims charged						
C Remainder of premium: (1) Retention charges (on an accrual basis)						
(A) Commissions	9c(1)(A)					
(B) Administrative service or other fees	9c(1)(B)					
(C) Other specific acquisition costs	9c(1)(C)					
(D) Other expenses	9c(1)(D)					
(E) Taxes	9c(1)(E)					
(F) Charges for risks or other contingencies	9c(1)(F)					
(G) Other retention charges		1.5 (1)	4.0			
(H) Total retention	_		(H)			
(2) Dividends or retroactive rate refunds. (These amounts were paid in	1-1		2)			
d Status of policyholder reserves at end of year: (1) Amount held to provide	benefits after r	•	<i>'</i>			
(2) Claim reserves		•	- 1			
(3) Other reserves		•	3)			
e Dividends or retroactive rate refunds due. (Do not include amount entered	d in line 9c(2) .)) 9e				
10 Nonexperience-rated contracts:		100				
a Total premiums or subscription charges paid to carrier			l l			
b If the carrier, service, or other organization incurred any specific costs in correction of the contract or policy, other than reported in Part I. line 3 above		401				
retention of the contract or policy, other than reported in Part I, line 2 abov Specify nature of costs.	re, report arriot	100	· I			
-1 7						
Part IV Provision of Information						
11 Did the insurance company fail to provide any information necessary to comp	lete Schedule	A? Yes	X No			
12 If the answer to line 11 is "Yes," specify the information not provided.						

SCHEDULE A (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

File as an attachment to Form 5500.

OMB No. 1210-0110

Employee Benefits Security Ad	ministration	F File as all a	machine in to Form 55	00.				
Pension Benefit Guaranty Co	orporation	•	es are required to provide the information o ERISA section 103(a)(2).			This I	This Form is Open to Public Inspection	
For calendar plan year 202	21 or fiscal pla	n year beginning 08/01/2021		and en	ding 07/3	1/2022		
A Name of plan ROCHESTER AREA CO	NSTRUCTION	AND MATERIALS HEALTH A			e-digit number (PN	u) >	501	
C Plan sponsor's name a		e 2a of Form 5500 AND MATERIALS HEALTH AND) WELFARE FUND		oyer Identifica 0962644	ation Numb	er (EIN)	
		rning Insurance Contract Lindividual contracts grouped as						
1 Coverage Information:								
(a) Name of insurance ca	N T	T	(e) Approximate nu	ımber of		Policy o	r contract year	
(b) EIN	(c) NAIC code	(d) Contract or identification number	persons covered a	t end of	(f)	From	(g) To	
15-0329043	55107	800632-2010	4	•	01/01/2021	1	12/31/2021	
2 Insurance fee and com- descending order of the		ation. Enter the total fees and tota	al commissions paid. Li	st in line 3	the agents,	brokers, an	d other persons in	
(a) Total a	amount of com	missions paid		(b) To	otal amount o	of fees paid		
3 Persons receiving com	missions and f	ees. (Complete as many entries	as needed to report all	persons).				
	(a) Name a	and address of the agent, broker,	or other person to whor	n commiss	ions or fees	were paid		
		Foo	s and other commission	oo poid				
(b) Amount of sales ar							(2) Organization and	
commissions pa	id	(c) Amount	(d) Purpose			(e) Organization code		
	(a) Name a	and address of the agent, broker,	or other person to whor	n commiss	ions or fees	were paid		
	,		·			•		
(b) Amount of sales and base Fees and other commissions paid								
commissions pa		(c) Amount		(d) Purpos	e		(e) Organization code	
For Donowyouls Dodgeste	am Ant Notice	and the Instructions for Form F	500			0-	hadula A (Form 5500) 2021	

Schedule A (Form 5500) 2	2021	Page 2 – 1			
(a) Na	me and address of the agent, brok	ker, or other person to whom commissions or fees were paid			
· ·					
		Fees and other commissions paid	(e)		
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code		
(a) Nai	ne and address of the agent, brok	ker, or other person to whom commissions or fees were paid	<u>'</u>		
	·		()		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
(a) Nai	ne and address of the agent, brok	ker, or other person to whom commissions or fees were paid			
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
(a) Nai	ne and address of the agent, brok	ker, or other person to whom commissions or fees were paid			
(I-) Assessment of a class and the con-		Fees and other commissions paid	(e)		
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code		
(a) Na	ne and address of the agent, brok	ker, or other person to whom commissions or fees were paid			
(a) itali	ne and addition of the agent, pro-	tor, or other person to whom commissions or roce were para			
Fees and other commissions paid					
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code		

Schedule A (Form 5500) 2021

	Part		idual contracto with cook corrier mou	ha traataa	log a unit for nurnage of
		Where individual contracts are provided, the entire group of such individual this report.	idual contracts with each camer may	De liealec	ras a unit for purposes or
4	Curr	ent value of plan's interest under this contract in the general account at year	end	4	
5	Curr	ent value of plan's interest under this contract in separate accounts at year e	nd	5	
6	Con	tracts With Allocated Funds:			
	а	State the basis of premium rates			
			1		
	b	Premiums paid to carrier		6b	
	C	Premiums due but unpaid at the end of the year		6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount	•	6d	
		Specify nature of costs			
		oposity flature of society			
	е	Type of contract: (1) individual policies (2) group deferred	d annuity		
			a armany		
		(3) other (specify)			
_	<u> </u>	If contract purchased, in whole or in part, to distribute benefits from a termin	<u> </u>		
1		tracts With Unallocated Funds (Do not include portions of these contracts ma			
	а		ate participation guarantee		
		(3) guaranteed investment (4) other			
	b	Balance at the end of the previous year		7b	
	С	Additions: (1) Contributions deposited during the year	7c(1)		
		(2) Dividends and credits	7c(2)		
		(3) Interest credited during the year	7c(3)		
		(4) Transferred from separate account	7c(4) 7c(5)		
		(5) Other (specify below)	70(3)		
		•			
				7 - (0)	
		(6)Total additions		7c(6)	
		Total of balance and additions (add lines 7b and 7c(6))		7d	
	E	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
		(2) Administration charge made by carrier	7e(2)		
		(3) Transferred to separate account	7e(3)		
		(4) Other (specify below)	7e(4)		
		•	- (- /		
		,			
		(E) Total de destace		70/F)	
	£	(5) Total deductions	ı	7e(5) 7f	
	I	Balance at the end of the current year (subtract line 7e(5) from line 7d)		11	

	he same employer(s) or members of the same employee organizations(s), ntracts are experience-rated as a unit. Where contracts cover individual carrier may be treated as a unit for purposes of this report.
8 Benefit and contract type (check all applicable boxes)	
a ☐ Health (other than dental or vision) b ☐ Dental	c ☐ Vision d ☐ Life insurance
e Temporary disability (accident and sickness) f Long-term disab	ility $\mathbf{g} \overline{ }$ Supplemental unemployment $\mathbf{h} \overline{ }$ Prescription drug
i ☐ Stop loss (large deductible) j ☐ HMO contract	k
	I I I dominity contract
m ☐ Other (specify) ▶	
9 Experience-rated contracts:	
a Premiums: (1) Amount received	9a(1)
(2) Increase (decrease) in amount due but unpaid	
(3) Increase (decrease) in unearned premium reserve	
(4) Earned ((1) + (2) - (3))	
b Benefit charges (1) Claims paid	
(2) Increase (decrease) in claim reserves	
(3) Incurred claims (add (1) and (2))	
(4) Claims charged	21 (1)
C Remainder of premium: (1) Retention charges (on an accrual basis)	
(A) Commissions	9c(1)(A)
(B) Administrative service or other fees	
(C) Other specific acquisition costs	0 (4)(0)
(D) Other expenses	9c(1)(D)
(E) Taxes	9c(1)(E)
(F) Charges for risks or other contingencies	9c(1)(F)
(G) Other retention charges	9c(1)(G)
(H) Total retention	
(2) Dividends or retroactive rate refunds. (These amounts were \infty paid	in cash, or credited.) 9c(2)
d Status of policyholder reserves at end of year: (1) Amount held to provid	
(2) Claim reserves	
(3) Other reserves	9d(3)
e Dividends or retroactive rate refunds due. (Do not include amount enter	
10 Nonexperience-rated contracts:	
a Total premiums or subscription charges paid to carrier	
b If the carrier, service, or other organization incurred any specific costs in retention of the contract or policy, other than reported in Part I, line 2 about Specify nature of costs.	
Part IV Provision of Information	
11 Did the insurance company fail to provide any information necessary to com	plete Schedule A? Yes X No
12 If the answer to line 11 is "Yes," specify the information not provided.	

SCHEDULE A (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

File as an attachment to Form 5500.

OMB No. 1210-0110

Employee Benefits Security Au	minotration	,					
Pension Benefit Guaranty Co	orporation	Insurance companies a pursuant to E	re required to provide th RISA section 103(a)(2).	e informat	ion	This Fo	m is Open to Public Inspection
For calendar plan year 202	21 or fiscal plar	n year beginning 08/01/2021		and en	ding 07/3	1/2022	
A Name of plan ROCHESTER AREA CO	NSTRUCTION	AND MATERIALS HEALTH A		B Three plan	e-digit number (PN	N) >	501
C Plan sponsor's name a		e 2a of Form 5500 AND MATERIALS HEALTH AND			yer Identific 0962644	ation Number	(EIN)
		rning Insurance Contract Individual contracts grouped as					
1 Coverage Information:							
(a) Name of insurance ca EXCELLUS HEALTH PLAI (b) EIN		(d) Contract or identification number	(e) Approximate nur persons covered at	end of	(5)	•	ontract year
	code	identification number	policy or contract	year	(1)	From	(g) To
15-0329043	55107	6914-0001	30		01/01/202	1	12/31/2021
descending order of the		ation. Enter the total fees and total	al commissions paid. Lis		the agents,		ther persons in
3 Persons receiving com		ees. (Complete as many entries					
(b) Amount of sales ar commissions pa	nd base	Fee: (c) Amount	s and other commission:			word pund	(e) Organization code
	(a) Name a	and address of the agent, broker,	or other person to whom	n commiss	ions or fees	were paid	
(h) Amount of colors	nd book	Fee:	s and other commission	s paid			
(b) Amount of sales ar commissions pa		(c) Amount		d) Purpose	Э		(e) Organization code

Schedule A (Form 5500) 2	2021	Page 2 – 1	
(a) Na	me and address of the agent, bro	oker, or other person to whom commissions or fees were paid	
	Г		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	me and address of the agent, bro	oker, or other person to whom commissions or fees were paid	
	T		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	me and address of the agent, bro	oker, or other person to whom commissions or fees were paid	
	ı		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	me and address of the agent, bro	oker, or other person to whom commissions or fees were paid	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	me and address of the agent, bro	oker, or other person to whom commissions or fees were paid	
	-		
			I
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
	l	1	I

Schedule A (Form 5500) 2021

ı	Part	II Investment and Annuity Contract Information			
		Where individual contracts are provided, the entire group of such indivi	dual contracts with each carrier ma	y be treated	as a unit for purposes of
4	Curr	this report. ent value of plan's interest under this contract in the general account at year of the second	and	4	
		ent value of plan's interest under this contract in the general accounts at year er		5	
		racts With Allocated Funds:			
Ū	a	State the basis of premium rates			
	_	Clate the same of promisin rates			
	b	Premiums paid to carrier		6b	
	С	Premiums due but unpaid at the end of the year		6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount		6d	
		Specify nature of costs			
	е	Type of contract: (1) ☐ individual policies (2) ☐ group deferred	d annuity		
		(3) other (specify)			
		(e) [] cance (ep cany)			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, check here		
7		racts With Unallocated Funds (Do not include portions of these contracts mai	<u> </u>		
•			te participation guarantee		
	а		te participation guarantee		
		(3) guaranteed investment (4) dother			
	L			71.	
	b	Balance at the end of the previous year		7b	
	С	Additions: (1) Contributions deposited during the year	7c(1) 7c(2)		
		(2) Dividends and credits	7c(3)		
		(4) Transferred from separate account	7c(4)		
		(5) Other (specify below)	7c(5)		
		b	13(3)		
		<i>'</i>			
		(O)T + 1 - 1 PC		70(6)	
	4	(6)Total additions		7c(6) 7d	
		Total of balance and additions (add lines 7b and 7c(6)) Deductions:		74	
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
		(2) Administration charge made by carrier	7e(2)		
		(3) Transferred to separate account	7e(3)		
		(4) Other (specify below)	7e(4)		
		b			
		,			
				7o/5\	
	_	(5) Total deductions		7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)		7 f	

Part III Welfare Benefit Contract Information If more than one contract covers the same group of employees of	the same employer(s) or members of the same employee organizations(s), ontracts are experience-rated as a unit. Where contracts cover individual
employees, the entire group of such individual contracts with each	
Benefit and contract type (check all applicable boxes)	
a ☐ Health (other than dental or vision) b ☐ Dental	c ☐ Vision d ☐ Life insurance
e ☐ Temporary disability (accident and sickness) f ☐ Long-term disa	bility g Supplemental unemployment h Prescription drug
i Stop loss (large deductible) j HMO contract	k ☐ PPO contract I ☐ Indemnity contract
m Other (specify)	_
9 Experience-rated contracts:	
a Premiums: (1) Amount received	9a(1)
(2) Increase (decrease) in amount due but unpaid	
(3) Increase (decrease) in unearned premium reserve	9a(3)
(4) Earned ((1) + (2) - (3))	9a(4)
b Benefit charges (1) Claims paid	·
(2) Increase (decrease) in claim reserves	9b(2)
(3) Incurred claims (add (1) and (2))	
(4) Claims charged	
C Remainder of premium: (1) Retention charges (on an accrual basis)	
(A) Commissions	9c(1)(A)
(B) Administrative service or other fees	
(C) Other specific acquisition costs	
(D) Other expenses	0.4440
(E) Taxes	0-(4)(5)
(F) Charges for risks or other contingencies	0 (4)(=)
(G) Other retention charges	0.747/07
(H) Total retention	0.4040
(2) Dividends or retroactive rate refunds. (These amounts were paid	
<u> </u>	
d Status of policyholder reserves at end of year: (1) Amount held to provi	
(2) Claim reserves	
(3) Other reserves	
Dividends or retroactive rate refunds due. (Do not include amount enter	red in line 9c(2).) 9e
10 Nonexperience-rated contracts:	40-
Total premiums or subscription charges paid to carrier	
b If the carrier, service, or other organization incurred any specific costs i	
retention of the contract or policy, other than reported in Part I, line 2 at Specify nature of costs.	pove, report amount
Specify flature of costs.	
Part IV Provision of Information	
11 Did the insurance company fail to provide any information necessary to con	nplete Schedule A? Yes X No
12 If the answer to line 11 is "Yes," specify the information not provided.	

SCHEDULE A (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

File as an attachment to Form 5500.

OMB No. 1210-0110

Pension Benefit Guaranty C	orporation	•	e companies are required to provide the information pursuant to ERISA section 103(a)(2).			This Form is Open to Public Inspection			
For calendar plan year 20		and en	ding 07/3	1/2022					
A Name of plan ROCHESTER AREA CO	NSTRUCTION	I AND MATERIALS HEALTH A		B Three plan	e-digit number (PN	J) •	501		
C Plan sponsor's name a		e 2a of Form 5500 AND MATERIALS HEALTH AI	ND WELFARE FUND	· ·	yer Identifica 0962644	ation Number	(EIN)		
	Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.								
1 Coverage Information:									
(a) Name of insurance ca UNITED HEALTH CARE I	C) NAIC	(d) Contract or	(e) Approximate no persons covered a				contract year		
(code	identification number	policy or contract		(f)	From	(g) To		
	55107	H2001	52		01/01/2021		12/31/2021		
2 Insurance fee and com descending order of the		ation. Enter the total fees and to	otal commissions paid. L	ist in line 3	the agents, I	orokers, and o	other persons in		
(a) Total	amount of com	missions paid		(b) To	tal amount o	of fees paid			
3 Persons receiving com	nmissions and f	ees. (Complete as many entrie	es as needed to report all	persons).					
		and address of the agent, broke	ees and other commissio		ons or fees	were paid	1		
(b) Amount of sales a commissions page		(c) Amount	(d) Purpose			(e) Organization code			
oominissions pe		(v) / aount		(a) i dipode			(a) organization code		
	(a) Name a	and address of the agent, broke	er, or other person to who	m commissi	ons or fees	were paid			
	(4)	and daying promo	., s. saus. peresa te une			е.о рала			
(b) Amount of sales a	nd hase	F	ees and other commissio	ns paid					
commissions pa		(c) Amount		(d) Purpose	9		(e) Organization code		

Schedule A (Form 5500) 2	021	Page 2 – 1			
(a) Nar	ne and address of the agent, brok	ker, or other person to whom commissions or fees were paid			
	, and the second				
	Fees and other commissions paid				
(b) Amount of sales and base	(c) Amount	(d) Purpose	(e) Organization		
commissions paid	(c) Amount	(a) i uipose	code		
(a) Nar	ne and address of the agent, brok	ker, or other person to whom commissions or fees were paid			
		Fees and other commissions paid	(e)		
(b) Amount of sales and base	(a) A t		Organization		
commissions paid	(c) Amount	(d) Purpose	code		
(a) Nar	ne and address of the agent, brok	ker, or other person to whom commissions or fees were paid			
		Fees and other commissions paid	(e)		
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code		
Sommoone paid			3333		
(a) Nar	ne and address of the agent, brok	ker, or other person to whom commissions or fees were paid			
42.4		Fees and other commissions paid	(e)		
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code		
(a) Nar	ne and address of the agent brok	ker, or other person to whom commissions or fees were paid	<u>.</u>		
(d) ivan	ne and address of the agent, bron	con other person to whom commissions of rees were paid			
		Fees and other commissions paid	(e)		
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code		

Schedule A (Form 5500) 2021

ı	Part	II Investment and Annuity Contract Information			
		Where individual contracts are provided, the entire group of such indivi	dual contracts with each carrier ma	y be treated	as a unit for purposes of
4	Curr	this report. ent value of plan's interest under this contract in the general account at year of the second	and	4	
		ent value of plan's interest under this contract in the general accounts at year er		5	
		racts With Allocated Funds:			
Ū	a	State the basis of premium rates			
	_	Clate the same of promisin rates			
	b	Premiums paid to carrier		6b	
	С	Premiums due but unpaid at the end of the year		6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount		6d	
		Specify nature of costs			
	е	Type of contract: (1) ☐ individual policies (2) ☐ group deferred	d annuity		
		(3) other (specify)			
		(e) [] cance (ep cany)			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, check here		
7		racts With Unallocated Funds (Do not include portions of these contracts mai	<u> </u>		
•			te participation guarantee		
	а		te participation guarantee		
		(3) guaranteed investment (4) dother			
	L			71.	
	b	Balance at the end of the previous year		7b	
	С	Additions: (1) Contributions deposited during the year	7c(1) 7c(2)		
		(2) Dividends and credits	7c(3)		
		(4) Transferred from separate account	7c(4)		
		(5) Other (specify below)	7c(5)		
		b	13(3)		
		<i>'</i>			
		(O)T + 1 - 1 PC		70(6)	
	4	(6)Total additions		7c(6) 7d	
		Total of balance and additions (add lines 7b and 7c(6)) Deductions:		74	
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
		(2) Administration charge made by carrier	7e(2)		
		(3) Transferred to separate account	7e(3)		
		(4) Other (specify below)	7e(4)		
		b			
		,			
				7o/5\	
	_	(5) Total deductions		7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)		7f	

P	Part III	Welfare Benefit Contract Informa If more than one contract covers the same the information may be combined for report employees, the entire group of such individ	group of employees of thing purposes if such con	tracts are	expe	erience-rated as a uni	it. Where co	ontracts cover individual
8	Benefit a	nd contract type (check all applicable boxes)			,	,		
	_	ealth (other than dental or vision)	b Dental		cП	Vision		d Life insurance
			=					
	브	mporary disability (accident and sickness)	f Long-term disabili	-		Supplemental unem	pioyment	h Prescription drug
	i St	op loss (large deductible)	j HMO contract		k _	PPO contract		I Indemnity contract
	m Ot	her (specify)						
9	Experience	ce-rated contracts:						
	a Prem	iums: (1) Amount received		9a(1)			
	(2) lı	ncrease (decrease) in amount due but unpaid	l	9a(2)			
	(S) I	ncrease (decrease) in unearned premium res	erve	9a(3))			
	(4) E	arned ((1) + (2) - (3))					. 9a(4)	
	b Ben	efit charges (1) Claims paid						
	` '	ncrease (decrease) in claim reserves					_	
	(3) lı	ncurred claims (add (1) and (2))					9b(3)	
	` '	Claims charged					9b(4)	
	C Ren	nainder of premium: (1) Retention charges (o	n an accrual basis)					
		(A) Commissions		9c(1)(
		(B) Administrative service or other fees		9c(1)(
		(C) Other specific acquisition costs		9c(1)(
		(D) Other expenses		9c(1)(
		(E) Taxes		9c(1)(_			
		(F) Charges for risks or other contingencies.		9c(1)(_			
		(G) Other retention charges					0c/1)/H	•
		(H) Total retention	_		_		9c(1)(H)	1
		Dividends or retroactive rate refunds. (These			_		9c(2)	
		us of policyholder reserves at end of year: (1	•				9d(1)	
	` '	Claim reserves					9d(2)	
	` '	Other reserves					9d(3)	
10		dends or retroactive rate refunds due. (Do no	ot include amount entere	a in line 9	C(2).)	9e	
10	•	erience-rated contracts:	orrior				100	
	_	al premiums or subscription charges paid to c					10a	
		e carrier, service, or other organization incurrention of the contract or policy, other than repo					10b	
		nature of costs.	onted in Fait 1, line 2 abov	re, report	anio	unt	100	
	, ,							
Р	art IV	Provision of Information						
11			ation necessary to comp	lata Saha	dula	Δ2 Π	Yes	X No
		insurance company fail to provide any inform		iete Sche	uule	Λ:	100	
14	if the ar	nswer to line 11 is "Yes," specify the informati	on not provided. 🔻					

SCHEDULE C (Form 5500)

Department of the Treasury Internal Revenue Service

Service Provider Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

OMB No. 1210-0110

	rtothement moonie occurry rtot or 101-	(Littort).	ı				
Department of Labor Employee Benefits Security Administration	▶ File as an attachment to Form 5500.		This Form is Open to Public Inspection.				
Pension Benefit Guaranty Corporation				·			
For calendar plan year 2021 or fiscal plan	n year beginning 08/01/2021	and ending 07/31	/2022				
A Name of plan		B Three-digit					
ROCHESTER AREA CONSTRUCTION	I AND MATERIALS HEALTH A	plan number (PN)	•	501			
				,			
C Plan sponsor's name as shown on line	e 2a of Form 5500	D Employer Identification	n Numbe	r (EIN)			
ROCHESTER AREA CONSTRUCTION	I AND MATERIALS HEALTH AND WELFARE FUND	16-0962644					
Port I Corning Drawider Infor	mation (and instructions)						
Part I Service Provider Infor	mation (see instructions)						
or more in total compensation (i.e., mor plan during the plan year. If a person re	ance with the instructions, to report the information requey or anything else of monetary value) in connection veceived only eligible indirect compensation for which tolude that person when completing the remainder of the	with services rendered to the plan received the requir	ne plan or	the person's position with the			
1 Information on Persons Rece	eiving Only Eligible Indirect Compensation	n					
	r you are excluding a person from the remainder of this		ed only eli	gible			
	n received the required disclosures (see instructions for	•	-	<u> </u>			
	e name and EIN or address of each person providing thation. Complete as many entries as needed (see instru		the servic	ce providers who			
(b) Enter name	e and EIN or address of person who provided you discl	osures on eligible indirect o	compensa	ition			
(b) Enter name	e and EIN or address of person who provided you discl	osures on eligible indirect o	compensa	ation			
(b) Futou nome	and CIN on address of manager who manifold you display	anna an alimible in dinast a		Al a ta			
(b) Enter name	e and EIN or address of person who provided you discl	osures on eligible indirect of	compensa	luon			
(b) Enter name	e and EIN or address of person who provided you disc	osures on eligible indirect of	compensa	ition			

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(b)	Enter name and EIN or address of person who provided you	disclosures on eligible indirect compensation
(b)	Enter name and EIN or address of person who provided you	disclosures on eligible indirect compensation
(b)	Enter name and EIN or address of person who provided you	disclosures on eligible indirect compensation
(b)	Enter name and EIN or address of person who provided you	disclosures on eligible indirect compensation
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(b)	Enter name and EIN or address of person who provided you	disclosures on eligible indirect compensation
(b)	Enter name and EIN or address of person who provided you	disclosures on eligible indirect compensation
(b)	Enter name and EIN or address of person who provided you	disclosures on eligible indirect compensation

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answered	"Yes" to line 1a above	e, complete as many	entries as needed to list ea	r Indirect Compensation ach person receiving, directly or the plan or their position with the	indirectly, \$5,000 or more in t	otal compensation
			(a) Enter name and EIN or	r address (see instructions)		
(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
			Yes No	Yes No		Yes No
			a) Enter name and EIN or	address (see instructions)		
(b) Service Code(s)	Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
			Yes No	Yes No		Yes No
		((a) Enter name and EIN or	address (see instructions)		
(b) Service Code(s)	Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
			Yes No	Yes No		Yes No

Schedule C (Form 5500) 2021	Page 3 - 2

answered	"Yes" to line 1a above	e, complete as many	entries as needed to list ea	or Indirect Compensation ach person receiving, directly or the plan or their position with the	indirectly, \$5,000 or more in t	total compensation
			(a) Enter name and EIN o	r address (see instructions)		
(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you	(h) Did the service provider give you a formula instead of an amount or estimated amount?
			Yes No	Yes No	answered "Yes" to element (f). If none, enter -0	Yes No
		(a) Enter name and EIN or	address (see instructions)		
(b) Service Code(s)	Relationship to employer, employer organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
			Yes No	Yes No		Yes No
		((a) Enter name and EIN or	address (see instructions)		
(b) Service Code(s)	Relationship to employer, employer organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
			Yes No	Yes No		Yes No

Schedule C (Form 5500) 2021

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Dout I Couries Dravider Information (continued)		
Part I Service Provider Information (continued) 3. If you reported on line 2 receipt of indirect compensation, other than eligible indirect competer or provides contract administrator, consulting, custodial, investment advisory, investment or questions for (a) each source from whom the service provider received \$1,000 or more in its provider gave you a formula used to determine the indirect compensation instead of an ammany entries as needed to report the required information for each source.	nanagement, broker, or recordkeeping ndirect compensation and (b) each so	g services, answer the following ource for whom the service
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	formula used to determine	compensation, including any the service provider's eligibility the indirect compensation.
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(C) Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	formula used to determine	compensation, including any the service provider's eligibility the indirect compensation.
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(C) Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	formula used to determine	compensation, including any the service provider's eligibility the indirect compensation.

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Part II Service Providers Who Fail or Refuse to F	Provide Infor	mation
		r who failed or refused to provide the information necessary to complete
(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(c) Describe the information that the service provider failed or refused to provide
(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(c) Describe the information that the service provider failed or refused to provide
(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(C) Describe the information that the service provider failed or refused to provide
(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(C) Describe the information that the service provider failed or refused to provide
(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(C) Describe the information that the service provider failed or refused to provide
(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(c) Describe the information that the service provider failed or refused to provide

Schedule C (Form 5500) 2021

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Part III Termination Information on Accountants and Enrolled Actuaries (see instructions) (complete as many entries as needed)				
	Name:	b EIN:		
	Position:			
d	Address:	e Telephone:		
Expl	planation:			
а	Name:	b EIN:		
	Position:			
d	Address:	e Telephone:		
Expl	planation:			
a	Name:	b EIN:		
	Position:			
d	Address:	e Telephone:		
Expl	olanation:			
а	Name:	b EIN:		
	Position:	D EIIV.		
	Address:	e Telephone:		
•	Addices.	• Totophone.		
Expl	planation:			
а	Name:	b EIN:		
	Position:			
	Address:	e Telephone:		
Expl	planation:			
Expl	planation:			

SCHEDULE H (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Financial Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA), and section 6058(a) of the Internal Revenue Code (the Code).

File as an attachment to Form 5500.

OMB No. 1210-0110

2021

This Form is Open to Public Inspection

Pension Benefit Guaranty Corporation				inspectio	n
For calendar plan year 2021 or fiscal plan year beginning 08/01/2021 and	endir	ng 07/31/2022			
A Name of plan ROCHESTER AREA CONSTRUCTION AND MATERIALS HEALTH A	В	Three-digit plan number (PN))	501
C Plan sponsor's name as shown on line 2a of Form 5500 ROCHESTER AREA CONSTRUCTION AND MATERIALS HEALTH AND WELFARE FUND	D	Employer Identifica 16-0962644	ition	Number (E	EIN)

Part I Asset and Liability Statement

1 Current value of plan assets and liabilities at the beginning and end of the plan year. Combine the value of plan assets held in more than one trust. Report the value of the plan's interest in a commingled fund containing the assets of more than one plan on a line-by-line basis unless the value is reportable on lines 1c(9) through 1c(14). Do not enter the value of that portion of an insurance contract which guarantees, during this plan year, to pay a specific dollar benefit at a future date. Round off amounts to the nearest dollar. MTIAs, CCTs, PSAs, and 103-12 IEs do not complete lines 1b(1), 1b(2), 1c(8), 1g, 1h, and 1i. CCTs, PSAs, and 103-12 IEs also do not complete lines 1d and 1e. See instructions.

Assets		(a) Beginning of Year	(b) End of Year
a Total noninterest-bearing cash	1a	9669	5003
b Receivables (less allowance for doubtful accounts):			
(1) Employer contributions	1b(1)	93200	92476
(2) Participant contributions	1b(2)		
(3) Other	1b(3)	17198	18771
c General investments:			
(1) Interest-bearing cash (include money market accounts & certificates of deposit)	1c(1)	198437	278605
(2) U.S. Government securities	1c(2)		
(3) Corporate debt instruments (other than employer securities):			
(A) Preferred	1c(3)(A)	709523	590730
(B) All other	1c(3)(B)	543285	806943
(4) Corporate stocks (other than employer securities):			
(A) Preferred	1c(4)(A)		
(B) Common	1c(4)(B)		
(5) Partnership/joint venture interests	1c(5)		
(6) Real estate (other than employer real property)	1c(6)		
(7) Loans (other than to participants)	1c(7)		
(8) Participant loans	1c(8)		
(9) Value of interest in common/collective trusts	1c(9)		
(10) Value of interest in pooled separate accounts	1c(10)		0
(11) Value of interest in master trust investment accounts	1c(11)		
(12) Value of interest in 103-12 investment entities	1c(12)		
(13) Value of interest in registered investment companies (e.g., mutual funds)	1c(13)	6075278	5000958
(14) Value of funds held in insurance company general account (unallocated contracts)	1c(14)		
(15) Other	1c(15)		

1d	mployer-related investments:		(a) Beginning of Year	(b) End of Year		
	(1) Employer securities	1d(1)				
	(2) Employer real property	1d(2)				
е	Buildings and other property used in plan operation	1e	160557	174166		
f	Total assets (add all amounts in lines 1a through 1e)	1f	7807147	6967652		
	Liabilities					
g	Benefit claims payable	1g				
h	Operating payables	1h	61691	49098		
i	Acquisition indebtedness	1i				
j	Other liabilities	1j	161542	110413		
k	Total liabilities (add all amounts in lines 1g through1j)	1k	223233	159511		
	Net Assets					
I	Net assets (subtract line 1k from line 1f)	11	7583914	6808141		

Part II Income and Expense Statement

Plan income, expenses, and changes in net assets for the year. Include all income and expenses of the plan, including any trust(s) or separately maintained fund(s) and any payments/receipts to/from insurance carriers. Round off amounts to the nearest dollar. MTIAs, CCTs, PSAs, and 103-12 IEs do not complete lines 2a, 2b(1)(E), 2e, 2f, and 2g.

	Income		(a) Amount	(b) Total		
а	Contributions:					
	(1) Received or receivable in cash from: (A) Employers	2a(1)(A)	5946588			
	(B) Participants	2a(1)(B)	632693			
	(C) Others (including rollovers)	2a(1)(C)				
	(2) Noncash contributions	2a(2)				
	(3) Total contributions. Add lines 2a(1)(A), (B), (C), and line 2a(2)	2a(3)		6579281		
b	Earnings on investments:					
	(1) Interest:					
	(A) Interest-bearing cash (including money market accounts and certificates of deposit)	2b(1)(A)	100			
	(B) U.S. Government securities	2b(1)(B)				
	(C) Corporate debt instruments	2b(1)(C)				
	(D) Loans (other than to participants)	2b(1)(D)				
	(E) Participant loans	2b(1)(E)				
	(F) Other	2b(1)(F)				
	(G) Total interest. Add lines 2b(1)(A) through (F)	2b(1)(G)		100		
	(2) Dividends: (A) Preferred stock	2b(2)(A)	39621			
	(B) Common stock	2b(2)(B)	4185			
	(C) Registered investment company shares (e.g. mutual funds)	2b(2)(C)	150158			
	(D) Total dividends. Add lines 2b(2)(A), (B), and (C)	2b(2)(D)		193964		
	(3) Rents	2b(3)				
	(4) Net gain (loss) on sale of assets: (A) Aggregate proceeds	2b(4)(A)	6392142			
	(B) Aggregate carrying amount (see instructions)	2b(4)(B)	6418857			
	(C) Subtract line 2b(4)(B) from line 2b(4)(A) and enter result	2b(4)(C)		-26715		
	(5) Unrealized appreciation (depreciation) of assets: (A) Real estate	2b(5)(A)				
	(B) Other	2b(5)(B)	-640329			
	(C) Total unrealized appreciation of assets. Add lines 2b(5)(A) and (B)	2b(5)(C)		-640329		

Schedule H (Form 5500) 2021

			(a) Am	ount			(b) Total	
(6) Net investment gain (loss) from common/collective trusts	2b(6)							
(7) Net investment gain (loss) from pooled separate accounts	2b(7)							
(8) Net investment gain (loss) from master trust investment accounts	2b(8)							
(9) Net investment gain (loss) from 103-12 investment entities	2b(9)							
(10) Net investment gain (loss) from registered investment companies (e.g., mutual funds)	2b(10)							
C Other income	2c						68170	
d Total income. Add all income amounts in column (b) and enter total	2d						6174471	
Expenses								
e Benefit payment and payments to provide benefits:								
(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)			3	16608			
(2) To insurance carriers for the provision of benefits	2e(2)			62	28172			
(3) Other	2e(3)							
(4) Total benefit payments. Add lines 2e(1) through (3)	2e(4)						6544780	
f Corrective distributions (see instructions)	2f							
g Certain deemed distributions of participant loans (see instructions)	2g							
h Interest expense	2h							
i Administrative expenses: (1) Professional fees	2i(1)			1	26021			
(2) Contract administrator fees	2i(2)							
(3) Investment advisory and management fees	2i(3)				59384			
(4) Other	0:/4)			2	20059			
(5) Total administrative expenses. Add lines 2i(1) through (4)	21/5						405464	
j Total expenses. Add all expense amounts in column (b) and enter total							6950244	
Net Income and Reconciliation								—
k Net income (loss). Subtract line 2j from line 2d	2k						-775773	
I Transfers of assets:							770770	
(1) To this plan	21(1)							
(2) From this plan								
(-)								_
Part III Accountant's Opinion								
3 Complete lines 3a through 3c if the opinion of an independent qualified pub attached.	lic accountant	is attached	to this	Form	5500. C	complete line	∍ 3d if an opinion is r	not
a The attached opinion of an independent qualified public accountant for this	· _ `	,						
(1) Unmodified (2) Qualified (3) Disclaimer	(4) Adverse							
b Check the appropriate box(es) to indicate whether the IQPA performed an ERISA section 103(a)(3)(C) audit. Check both boxes (1) and (2) if the audit was performed pursuant to both 29 CFR 2520.103-8 and 29 CFR 2520.103-12(d). Check box (3) if pursuant to neither.								
(1) DOL Regulation 2520.103-8 (2) DOL Regulation 2520.103-12(d)	(3) X neither D	OL Regula	ition 25	20.10	3-8 nor	DOL Regula	ation 2520.103-12(d)	1-
C Enter the name and EIN of the accountant (or accounting firm) below:								
(1) Name: STOKES, VISCA, HUCKO & BARONE, CPAS		(2) EIN	: 47-4	21531	3			
d The opinion of an independent qualified public accountant is not attached								
(1) This form is filed for a CCT, PSA, or MTIA. (2) It will be attached to the next Form 5500 pursuant to 29 CFR 2520.104-50.								
Part IV Compliance Questions								
4 CCTs and PSAs do not complete Part IV. MTIAs, 103-12 IEs, and GIAs of 103-12 IEs also do not complete lines 4j and 4l. MTIAs also do not complete lin		e lines 4a, 4	4e, 4f,	4g, 4h	, 4k, 4m	, 4n, or 5.		
During the plan year:	During the plan year: Yes No Amount							
Was there a failure to transmit to the plan any participant contributions w period described in 29 CFR 2510.3-102? Continue to answer "Yes" for an fully corrected. (See instructions and DOL's Voluntary Fiduciary Correction	ny prior year fa		45		X			
runy corrected. (See instructions and DOL'S voluntary Fiduciary Correction	ייר רוטgram.)		4a		^			

1

Schedule H (Form 5500) 2021 Page **4-**

			Yes	No	Amo	unt	
b	Were any loans by the plan or fixed income obligations due the plan in default as of the close of the plan year or classified during the year as uncollectible? Disregard participant loans secured by participant's account balance. (Attach Schedule G (Form 5500) Part I if "Yes" is checked.)						
С	Were any leases to which the plan was a party in default or classified during the year as uncollectible? (Attach Schedule G (Form 5500) Part II if "Yes" is checked.)	4c		X			
d	Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 4a. Attach Schedule G (Form 5500) Part III if "Yes" is						
	checked.)			X			
е	Was this plan covered by a fidelity bond?	4e	X			1000000	
f	Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?	4f		X			
g	Did the plan hold any assets whose current value was neither readily determinable on an established market nor set by an independent third party appraiser?	4g		X			
h	Did the plan receive any noncash contributions whose value was neither readily determinable on an established market nor set by an independent third party appraiser?	4-		X			
i	Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.)	4h		^			
i	Were any plan transactions or series of transactions in excess of 5% of the current	4i	X				
J	value of plan assets? (Attach schedule of transactions if "Yes" is checked and see instructions for format requirements.)	4j	X				
k	Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?	4k		X			
I	Has the plan failed to provide any benefit when due under the plan?	41		X			
m	If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)	4m		X			
n	If 4m was answered "Yes," check the "Yes" box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3	4n		X			
5a	Has a resolution to terminate the plan been adopted during the plan year or any prior plan year?	s X	No				
5b	If, during this plan year, any assets or liabilities were transferred from this plan to another plan(s), ide transferred. (See instructions.)	ntify t	he plar	n(s) to w	hich assets or liab	ilities were	
	5b(1) Name of plan(s)					5b(3) PN(s)	
	Vas the plan a defined benefit plan covered under the PBGC insurance program at any time during this						
instructions.) Yes No Not determined							
IT	"Yes" is checked, enter the My PAA confirmation number from the PBGC premium filing for this plan y	rear_					

ROCHESTER AREA CONSTRUCTION AND MATERIALS TEAMSTERS HEALTH AND WELFARE FUND

FINANCIAL STATEMENTS JULY 31, 2022 AND 2021

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Certified Public Accountants INDEPENDENT AUDITOR'S REPORT

To the Board of Trustees Rochester Area Construction and Materials Teamsters Health and Welfare Fund Rochester, New York

Opinion

We have audited the accompanying financial statements of Rochester Area Construction and Materials Teamsters Health and Welfare Fund, an employee benefit plan subject to the Employee Retirement Income Security Act of 1974 (ERISA), which comprise the statements of net assets available for benefits as of July 31, 2022 and 2021, and the related statements of changes in net assets available for benefits for the years then ended, and the related notes to the financial statements.

In our opinion, the financial statements referred to above present fairly, in all material respects, the net assets available for benefits of Rochester Area Construction and Materials Teamsters Health and Welfare Fund as of July 31, 2022 and 2021, and the changes in its net assets available for benefits for the years then ended, in accordance with accounting principles generally accepted in the United States of America.

Responsibilities of Management for the Financial Statements

Management is responsible for the preparation and fair presentation of the financial statements in accordance with accounting principles generally accepted in the United States of America, and for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about Rochester Area Construction and Materials Teamsters Health and Welfare Fund's ability to continue as a going concern for one year after the date the financial statements are available to be issued.

Management is also responsible for maintaining a current plan instrument, including all plan amendments, administering the plan, and determining that the plan's transactions that are presented and disclosed in the financial statements are in conformity with the plan's provisions, including maintaining sufficient records with respect to each of the participants, to determine the benefits due or which may become due to such participants.

Auditor's Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with generally accepted auditing standards will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the financial statements.

In performing an audit in accordance with generally accepted auditing standards, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the financial statements, whether
 due to fraud or error, and design and perform audit procedures responsive to those risks.
 Such procedures include examining, on a test basis, evidence regarding the amounts and
 disclosures in the financial statements.
- Obtain an understanding of internal control relevant to the audit in order to design audit
 procedures that are appropriate in the circumstances, but not for the purpose of
 expressing an opinion on the effectiveness of Rochester Area Construction and Materials
 Teamsters Health and Welfare Fund's internal control. Accordingly, no such opinion is
 expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the
 aggregate, that raise substantial doubt about Rochester Area Construction and Materials
 Teamsters Health and Welfare Fund's ability to continue as a going concern for a
 reasonable period of time.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control-related matters that we identified during the audit.

Supplemental Schedules Required by ERISA

Our audits were conducted for the purpose of forming an opinion on the financial statements as a whole. The supplemental schedules of A, B, and C, for the year ended July 31, 2022 together referred to as "supplemental information," are presented for purposes of additional analysis and are not a required part of the financial statements but are supplementary information required by the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information has been subjected to the auditing procedures applied in the audits of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with generally accepted auditing standards.

In forming our opinion on the supplemental schedules, we evaluated whether the supplemental schedules, including their form and content, are presented in conformity with the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA.

In our opinion, the information in the accompanying schedules is fairly stated, in all material respects, in relation to the financial statements as a whole, and the form and content are presented in conformity with the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA.

Prior Period Financial Statements

The financial statements as of July 31, 2021, were audited by Sean Hucko, CPA, LLC, who merged with Stokes, Visca, Hucko & Barone, CPAs, LLC as of January 1, 2022, and whose report dated November 30, 2021, stated that the financial statements present fairly, in all material respects, the net assets available for benefits of Rochester Area Construction and Materials Teamsters Health and Welfare Fund as of July 31, 2021, and the changes in its net assets available for benefits for the years then ended, in accordance with accounting principles generally accepted in the United States of America.

Stokes, Visca, Hucko & Barone, CPAs, LLC

Stokes, Visca, Hucko & Barone, CPAs, LLC Rochester, New York November 30, 2022

Case 6:24-cv-06030-CJS Document 1-1 Filed 01/16/24 Page 113 of 129 ROCHESTER AREA CONSTRUCTION AND MATERIALS TEAMSTERS HEALTH AND WELFARE FUND STATEMENTS OF NET ASSETS AVAILABLE FOR BENEFITS JULY 31, 2022 AND 2021

		July 31, 2022		July 31, 2021
ASSETS				
Investments at Fair Value				
Money Market Funds	\$	150,636	\$	51,586
Common Stocks		806,943		543,285
Preferred Securities		590,730		709,523
Mutual Funds and Exchange Traded Funds		5,000,958		6,075,278
Total Investments		6,549,267	410	7,379,672
Receivables				
Employer Contributions Receivable		92,476		93,200
Interest and Dividends		2,148		2,728
Total Receivables		94,624		95,928
Other Current Assets				
Due from Rochester Area Contruction and Materials				
Teamster Annuity Fund		16 622		14.470
Property, Plant and Equipment - Net		16,623 1,396		14,470
Prepaid Expenses		1,396		1,889
Total Other Current Assets		190,789		158,668
Total Other Current Assets		190,789		175,027
Cash and Cash Equivalents	<u> </u>	132,972	59	156,520
TOTAL ASSETS		6,967,652		7,807,147
LIABILITIES				
Accounts Payable		49,098		61,691
Deferred Employer Contributions		108,682		159,988
Accrued and Withheld Payroll Taxes		595		418
Compensated Absences (Vacation and Sick Time)		1,136		1,136
TOTAL LIABILITIES	-	159,511	·	223,233
	*	107,011		
NET ASSETS AVAILABLE FOR BENEFITS	S	6,808,141	\$	7,583,914

ROCHESTER AREA CONSTRUCTION AND MATERIALS TEAMSTERS HEALTH AND WELFARE FUND STATEMENTS OF CHANGES IN NET ASSETS AVAILABLE FOR BENEFITS FOR THE YEARS ENDED JULY 31, 2022 AND 2021

	July 31, 2022	July 31, 2021
ADDITIONS TO NET ASSETS ATTRIBUTED TO Investment Income:		
Net Appreciation/(Depreciation) in Fair Value of Investments	\$ (667,044)	\$ 1,415,272
Investment Interest Income	85	11
Dividend Income	193,964	233,582
Total Investment Income	(472,995)	1,648,865
Less: Investment Expense	(59,384)	(55,022)
Net Investment Income	(532,379)	1,593,843
Contributions:		
Employer Contributions	5,946,588	6,015,530
Participant Contributions	632,693	673,621
Total Contributions	6,579,281	6,689,151
Other Income:		
Administrative Fee	51,547	51,136
Allocation of Annuity Expense to Annuity Fund	16,623	14,470
Interest on Bank Accounts	15	48
Total Other Income	68,185	65,654
TOTAL ADDITIONS	6,115,087	8,348,648
DEDUCTIONS FROM NET ASSETS ATTRIBUTED TO		
Benefits Paid to/for Participants:		
Health Care	5,939,687	6,121,689
Optical Benefits	205,992	216,916
Disability and Death	56,794	58,256
Health Reimbursement	316,608	283,747
Legal Benefit	25,699	34,891
Total Benefits Paid	6,544,780	6,715,499
Administrative Expenses:		
Salaries and Benefits	97,657	93,540
Office Expense	64,497	48,067
Legal Fees	18,571	21,522
Depreciation Expense	493	493
Accounting Fees	18,856	18,056
Other Professional Fees	17,591	23,979
Trustee Expense Broker Fees - Aetna	3,855 71,003	2,872
Patient Centered Outcomes Research Trust Fund Fees	2,010	61,526 1,455
Administrative Fee	51,547	51,136
Total Administrative Expenses	346,080	322,646
	- 010,000	
TOTAL DEDUCTIONS	6,890,860	7,038,145
CHANGE IN NET ASSETS AVAILABLE FOR BENEFITS	(775,773)	1,310,503
Net Assets Available for Benefits		
Beginning of Year	7,583,914	6,273,411
NET ASSETS AVAILABLE FOR BENEFITS		
END OF YEAR	\$ 6,808,141	\$ 7,583,914

Note 1 - Description of The Plan

The following description of the Rochester Area Construction and Materials Teamsters Health and Welfare Fund (the Plan) provides only general information. Participants should refer to the Plan Agreement for a complete description of the Plan's provisions.

General

Rochester Area Construction and Materials Teamsters Health and Welfare Fund was authorized initially by a collective bargaining agreement between Teamsters Local 118, which is affiliated with the International Brotherhood of Teamsters and the Labor Relations Division of Associated Contractors of America, New York Chapter, Inc.

Contributions

The Plan agreements provide that an employer make monthly contributions to the Plan for each hour worked by the participant. Each employer's contribution rate is determined by individual collective bargaining agreements. The contributions are allocated to each participant's individual benefit account. Individuals who participate in Rochester Area Construction and Materials Teamsters Health and Welfare Fund will participate in Rochester Area Construction and Materials Teamsters Annuity Fund, an affiliated plan, if they have an account balance in Rochester Area Construction and Materials Teamsters Health and Welfare Fund as of the last day of that plan's previous plan year of at least \$3,200. For those participants, an employer contribution of 7 cents per hour will be made to the participant's account in Rochester Area Construction Teamsters and Materials Annuity Fund, with a corresponding 7 cents per hour reduction to the participant's account in Rochester Area Construction and Materials Teamsters Health and Welfare Fund.

If an eligible employee had an account balance of \$10,000 or more in Rochester Area Construction and Materials Teamsters Health and Welfare Fund as of the prior July 31, a larger contribution will be made to the participant's account in Rochester Area Construction and Materials Teamsters Annuity Fund account. This larger amount will be determined by reducing to one dollar per hour the contribution made to Rochester Area Construction and Materials Teamsters Health and Welfare Fund and contributing the remaining portion of the contribution which would have been made to Rochester Area Construction and Materials Health and Welfare Fund, to Rochester Area Construction and Materials Annuity Fund.

The Plan currently allows an individual participant to select their benefit coverage as desired provided that certain established criteria have been met with respect to the amount posted to the participant's individual benefit account. The types of coverage include a medical insurance benefit plan, an optical benefit plan, a physical examination plan and a dental insurance benefit plan. The Plan provides that a participant may self-pay for any portion of his benefit coverage should the employer contributions in his individual benefit account be inadequate to pay for the selected coverage or to maintain coverage during periods of unemployment.

Other

The Plan and the acts and decisions made by the Trustees will be binding upon all participants and beneficiaries and upon the heirs, executors and administrators of any participant, beneficiary or person claiming any benefit hereunder.

Note 2 - Summary of Significant Accounting Policies

Basis of Accounting

The accompanying financial statements are prepared on the accrual basis of accounting.

Cash and Cash Equivalents

Cash and cash equivalents include time deposits, certificates of deposit, and all highly liquid debt instruments with original maturities of three months or less, excluding amounts maintained in investment portfolios. At times, balances may be in excess of FDIC insurance limits.

Use of Estimates

The preparation of financial statements in accordance with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and therein, and disclosure of contingent assets and liabilities. Actual results could differ from those estimates.

Employer Contribution Receivable

Employer contributions receivable are determined through analysis of employer reports and remittances received through September 2022 and 2021. Any amounts found in subsequent months to be uncollectible are charged against the reserve for uncollectibles.

Payment of Benefits

Benefits are recorded when paid.

Investment Valuation and Income Recognition

The Plan's investments are reported at fair value. Fair value is the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. See Note 3 for discussion of fair value measurements. Purchases and sales of securities are recorded on a trade-date basis. Net appreciation includes the Plan's gains and losses on investments bought and sold as well as held during the year.

Tax Status

The Plan obtained its latest determination letter on May 18, 1973, in which the Internal Revenue Service stated that the plan, as then designed, was in compliance with the applicable requirements of the Internal Revenue Code. The Plan has been amended since receiving the determination letter. However, the Plan management and the plan's tax counsel believe that the Plan is currently designed and being operated in compliance with the applicable requirements of the Internal Revenue Code. The Plan is exempt from federal income taxes under current provisions of the Internal Revenue Code Section 501 (c) (9). The Plan administrator believes that the Plan is designed and is currently being operated in compliance with the applicable requirements of the IRC and therefore believes that the Plan is qualified and the related trust is tax-exempt. Accounting principles generally accepted in the United States of America require plan management to evaluate tax positions taken by the Plan and recognize a tax liability if the Plan has taken an uncertain position that more likely than not would not be sustained upon examination by the IRS. The Plan is subject to routine audits by taxing jurisdictions; however, there are currently no audits for any tax periods in progress.

Funding

The Plan is funded by contributions from employers as set by union-negotiated contracts.

Date of Management's Review

The Plan has evaluated subsequent events though November 30, 2022 the date the financial statements were available to be issued.

Note 3 - Investments - Fair Value Measurements

ASC 820, Fair Value Measurement, establishes a framework for measuring fair value. That framework provides a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (level 1 measurements) and the lowest priority to unobservable inputs (level 3 measurements), The three levels of fair value hierarchy under the ASC 820 are described as follows:

<u>Level 1</u>: Inputs to the valuation methodology are unadjusted quoted prices for identical assets or liabilities in active markets that the Plan has the ability to access.

<u>Level 2</u>: Inputs to the valuation methodology include:

- Quoted prices for similar assets or liabilities in active markets;
- Quoted prices for identical or similar assets or liabilities in inactive markets;
- Inputs other than quoted prices that are observable for the asset or liability; and
- Inputs that are derived principally from or corroborated by observable market data by correlation or other means.

If the asset or liability has a specified (contractual) term, the level 2 input must be observable for substantially the full term of the asset or liability.

<u>Level 3</u>: Inputs to the valuation methodology are unobservable and significant to the fair value measurement.

The asset or liability's fair value measurement level within the fair value hierarchy is based on the lowest level of any input that is significant to the fair value measurement. Valuation techniques maximize the use of relevant observable inputs and minimize the use of unobservable inputs.

The following is a description of the valuation methodologies used for assets measured at fair value. There have been no changes in the methodologies used at July 31, 2022 and 2021.

Money Market Funds: Valued at cost, which approximates fair value.

Common Stocks and Corporate Issues: Valued at the closing price reported on the active market on which the individual securities are traded.

Preferred Securities: Certain preferred securities are valued at the closing price reported on the active market on which the securities are traded. Other preferred securities are valued based on quoted prices for similar assets liabilities in active markets or quoted prices for identical or similar assets or liabilities in inactive markets.

Mutual Funds and Exchange Traded Funds: Closed-end mutual funds and exchange traded funds are valued at the closing price reported on the active market on which the individual securities are traded. Open-end mutual funds are registered with the Securities and Exchange Commission and are required to publish their daily net assets value (NAV) and to transact at that price. The mutual funds held by the Plan are deemed to be actively traded.

The following table sets forth by level, within the fair value hierarchy, the Plan's assets at fair value as of July 31, 2022:

	Level 1	Level 2	Level 3	<u>Total</u>
Money Market Funds	\$ 150,636	\$ -	\$ -	\$ 150,636
Common Stocks	806,943	-	-	806,943
Preferred Securities	590,730	-	:-	590,730
Mutual Funds and Exchange Traded Funds	5,000,958			5,000,958
Total Investments at Fair Value	\$ 6,549,267	s -	s -	\$ 6,549,267

The following table sets forth by level, within the fair value hierarchy, the Plan's assets at fair value as of July 31, 2021:

	Level 1	Level 2	Level 3	<u>Total</u>
Money Market Funds	\$ 51,586	\$ -	\$ -	\$ 51,586
Common Stocks	543,285	-	-	543,285
Preferred Securities	709,523		-	709,523
Mutual Funds and Exchange Traded Funds	6,075,278			6,075,278
Total Investments at Fair Value	\$ 7,379,672	\$ -	\$ -	\$ 7,379,672

Note 4 - Property and Equipment

Office equipment and related accumulated depreciation is as follows at July 31, 2022 and 2021:

	2022	2021
Office Equipment	\$ 41,753	\$ 41,753
Accumulated Depreciation	(40,357)	(39,864)
Net	\$ 1,396	\$ 1,889

Depreciation expense was \$493 for the years ended July 31, 2022 and 2021.

Note 5 - Plan Termination

The Plan was negotiated as a permanent program, however, it could be terminated at any time in the future through collective bargaining negotiations or by the Trustees, but only with consent of the Union and the contributing employers. In the event of the termination of the Trust Fund, the trustees shall thereupon allocate and distribute the assets of the Fund in accordance with the applicable provisions of Employee Retirement Income Security Act.

Note 6 - Administrative Fee

The Plan charges non-self contributing individual participants an administrative fee of either \$1, \$2 or \$3 per month. For individual participants that only have the Vision Plan, a reduced fee of \$1 per month is available. Participants with medical pay \$2 per month. Participants with legal benefit and have health insurance pay \$3 per month. These fees totaled \$51,547 and \$51,136 for the years ended July 31, 2022 and 2021, respectively.

Note 7 - Medical Insurance Premiums

The Plan, at the discretion of the Trustees, uses excess earnings of the Administrative Fund to reduce the cost of the medical insurance premiums for certain eligible participants. The trustees are free to discontinue this policy at any time. Amounts totaling \$136,450 and \$204,700 were transferred from unassigned funds into individual accounts in the fiscal years ended July 31, 2022 and 2021, respectively.

Note 8 - Group Life and Accidental Death and Dismemberment Insurance Policy

Certain eligible participants are covered under a group life and accidental death and dismemberment insurance policy. The premiums for this policy are paid out of the Administrative Fund, and amounted to \$56,794 and \$58,256 for the years ended July 31, 2022 and 2021, respectively.

Note 9 - Prescription Drug Benefits

The Plan provides a prescription drug plan that is available for members who are currently enrolled in Medicare that will provide coverage equivalent to Medicare Part D coverage.

Note 10 - Related Party Transactions

1. Rochester Area Construction and Materials Teamsters Health and Welfare Fund has an agreement with Rochester Area Construction and Materials Teamster Annuity Fund to provide it with office space, administrative services and other direct costs necessary for the operation of Rochester Area Construction and Materials Teamsters Annuity Fund. The administration fee of \$16,623 and \$14,470 charged to Rochester Area Construction and Materials Teamsters Annuity Fund by Rochester Area Construction and Materials Teamsters Health and Welfare Fund during the years ended July 31, 2022, and 2010, respectively, relates to common indirect expenses incurred by both Funds and are allocated to Rochester Area Construction and Materials Teamsters Annuity Fund based on management's estimate of common expenses. Rochester Area Construction and Materials Teamsters Health and Welfare Fund is due from Rochester Area Construction and Materials Teamsters Annuity Fund in the amounts of \$16,623 and \$14,470, as of July 31, 2022 and 2021 respectively, as reported in the statement of net assets available for benefits.

The Fund leases office space from the Teamsters Local Union No. 118 Building Corp., a related party, at the monthly rate of \$750 until May 31, 2022. The lease has not been renewed as of the date of these financial statements. The Plan continues to pay \$750 per month.

Note 11 - Office Lease

The Plan renewed their lease effective June 1, 2016 at \$641.67 per month through May 31, 2019. The lease was renewed until May 31, 2022 in the amount of \$750 per month. Rent expense amounted to \$9,000 and \$9,000 for the years ended July 31, 2022 and 2021, respectively. The lease has not been renewed as of the date of these financial statements. The Plan continues to pay \$750 per month.

Note 12 - Employee Pension and Retirement

The employee of Rochester Area Construction and Materials Teamster Health and Welfare Fund is covered by the New York State Teamsters Conference Pension and Retirement Fund, which is a multi-employer defined benefit plan. Expense charged to operations amounted to \$3,600 and \$3,540 for the years ended July 31, 2022 and 2021, respectively.

Note 13 - Other

The Plan's Board of Trustees, as Sponsor, has the right under the Plan to modify the benefits provided to active employees. The Plan may be terminated only by joint agreement between industry and union, subject to the provisions set forth in ERISA.

Note 14 - Concentrations

The Plan as a provider of benefits receives employer contributions. A majority of these employers are contractors in the Greater Rochester area and their ability to fulfill their commitment is dependent upon that area's business economic sector.

Note 15 - Plan Amendments

The Plan has been in effect since January 24, 1968. The most recent restatement of the Plan was effective on January 1, 1992. Below are recent amendments to the Plan.

Effective January 1, 2013 the Board of Trustees passed an amendment that deleted the entitled Grandfathered Plan Status section.

Effective January 1, 2013 the Board of Trustees passed an amendment that added additional internal appeal procedures to the Section entitled Claim Denials and Appeals.

Effective January 1, 2013 the Board of Trustees passed an amendment that changed the Subsection entitled The Trustees' Decision are Final and Binding. The changes added to the External Reviewer's final decision will be final and binding.

Note 16 - Risks and Uncertainties

The plan invests in various investment securities. Investment securities are exposed to various risks such as interest rate, market, and credit risks. Due to the level of risk associated with certain investment securities, it is at least reasonably possible that changes in the values of investment securities will occur in the near term and that such changes could materially affect the amounts reported in the statement of net assets available for benefits.

Note 17 - Subsequent Events

The Plan has evaluated subsequent events though November 30, 2022, the date the financial statements were available to be issued.

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SCHEDULE H, LINE 4I - SCHEDULE OF ASSETS (HELD AT END OF YEAR) July 31, 2022

EIN: 16-0962644 PLAN NUMBER: 501

Supplemental Schedule A

				(e)	Current
(a)	(b) Identity of Issue	(c) Description of Investment	(d) Cost	0.000.00	Value
*	US Bank Mmda Global Fund Services	Money Market Funds	\$ 150,636	\$	150,636
	Bannix Acquisition Corp Com	Common Stock	150,399		152,694
	Gigcapital 5 Inc	Common Stock	149,273		151,001
	McLaren Technology Acq Corp Class A	Common Stock	152,611		156,028
	Mountain Crest Acqusitn Crp IV Com	Common Stock	146,550		148,275
	Neuberger Berman Nest Generation	Common Stock	89,419		62,202
	Property Solutions Acquisition	Common Stock	138,134		136,743
	First Eagle Altr Ser 5.0% Preferred	Preferred Securities	116,250		110,670
	Gladstone Invt Corp 5.0% Preferred	Preferred Securities	140,625		133,313
	Oxford Lane Cap Ser 2024 6.75%		39,045		40,881
	Preferred	Preferred Securities	**************************************		
	Phenixfin Corp 6.125% Preferred	Preferred Securities	23,450		23,557
	Priority Income Fund Ser H 6.0%		145,373		143,559
	Preferred	Preferred Securities	0 00.45 0.5		
	Terra Inc Fund 6 Ser 7.0% Preferred	Preferred Securities	137,940		138,750
	Ares Acquisition Corporation Com	Foreign Stock	146,700		148,050
	Tiga Acquisition Corp	Foreign Stock	156,002		158,928
	Vahanna Tech Edge Acqstn I Crp Class	Foreign Stock	151,623		153,383
	Aberdeen Emerging Markets Equity		151,025		155,505
	Income	Mutual Funds and Exchange Traded Funds	38,799		22,484
	Aberdeen Emerging Markets Equity Inco	Mutual Funds and Exchange Traded Funds	29,997		24,870
	Blackrock Global Energy & Res Tr	Mutual Funds and Exchange Traded Funds	19,048		18,322
	Blackrock Enhd Glb Div Trt	Mutual Funds and Exchange Traded Funds	28,918		38,265
	Blackrock Enhed Intl Div Trt	Mutual Funds and Exchange Traded Funds	21,418		20,830
	Blackrock Science And Technology	Mutual Funds and Exchange Traded Funds	37,770		27,491
	Blackrock Health Sci Tr II	Mutual Funds and Exchange Traded Funds	13,357		14,272
	Blackrock Science Technology Trust	Mutual Funds and Exchange Traded Funds	11,211		9,309
	Blackrock Innovation And Grw	Mutual Funds and Exchange Traded Funds	42,078		25,272
	Gabelli Divid & Income Tr	Mutual Funds and Exchange Traded Funds	53,290		75,418
	Invesco QQQ Trust Etf	Mutual Funds and Exchange Traded Funds	74,425		80,442
	Invesco S P 500 Equal Weight ETF	Mutual Funds and Exchange Traded Funds	44,797		47,398
	Ishares Msci Canada ETF	Mutual Funds and Exchange Traded Funds	44,268		55,790
	Ishares Msci Global Min Vol Etf	Mutual Funds and Exchange Traded Funds	54,351		54,695
	Ishares Msci Emerging Markets Etf	Mutual Funds and Exchange Traded Funds	27,657		25,735
	Ishares Msci Switzerland Etf	Mutual Funds and Exchange Traded Funds	20,442		21,310
	Ishares S&P Global Energy Etf	Mutual Funds and Exchange Traded Funds	19,146		18,669
	Ishares Russell 1000 ETF	Mutual Funds and Exchange Traded Funds	159,155		178,211
	Ishares Europe Etf	Mutual Funds and Exchange Traded Funds	50,280		52,570
	Ishares Msci Acwi Ex US Etf	Mutual Funds and Exchange Traded Funds	39,878		33,494
	Ishares Msci Acwi Etf	Mutual Funds and Exchange Traded Funds	45,964		40,419
	Ishares Msci China Etf	Mutual Funds and Exchange Traded Funds	29,761		27,826
	Ishares Msci Japan Etf	Mutual Funds and Exchange Traded Funds	65,302		62,046

^{*} Denotes party-in-interest

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HEALTH AND WELFARE FUND

SCHEDULE H, LINE 4I - SCHEDULE OF ASSETS (HELD AT END OF YEAR) July 31, 2022

EIN: 16-0962644 PLAN NUMBER: 501

Supplemental Schedule A

()	(h) Identities of Leave		(A) C	(e) Current
(a)		(c) Description of Investment	(d) Cost	Value
	Ishares Msci Intl Quality Factor Etf	Mutual Funds and Exchange Traded Funds	11,822	11,196
	Ishares Msci United Kingdom Etf	Mutual Funds and Exchange Traded Funds	22,578	21,946
	Japan Smaller Capitalization Fd Inc	Mutual Funds and Exchange Traded Funds	22,392	15,510
	Mainstay Cbre Glob Infra Megatrends	Mutual Funds and Exchange Traded Funds	45,964	46,135
	M S D W India Investment Fund	Mutual Funds and Exchange Traded Funds	20,791	18,977
	Royce Micro Cap Tr Inc	Mutual Funds and Exchange Traded Funds	45,228	48,331
	Energy Select Sector Spdr Fund Etf	Mutual Funds and Exchange Traded Funds	27,595	27,839
	Vanguard Dividend Appreciation Etf	Mutual Funds and Exchange Traded Funds	82,164	83,505
	Vanguard Information ETF	Mutual Funds and Exchange Traded Funds	79,897	105,507
	Vanguard Ftse Emerging Markets ETF	Mutual Funds and Exchange Traded Funds	192,235	174,990
	Vanguard Ftse Pacific Index Fund ETF	Mutual Funds and Exchange Traded Funds	49,197	51,490
	Vanguard Ftse Europe Index Fund ETF	Mutual Funds and Exchange Traded Funds	259,171	257,057
	Vanguard S P 500 ETF	Mutual Funds and Exchange Traded Funds	1,421,078	1,575,766
	Vanguard Value Index Fund ETF	Mutual Funds and Exchange Traded Funds	86,353	83,823
	Vanguard Small Cap Index Fund ETF	Mutual Funds and Exchange Traded Funds	146,517	168,493
	Vanguard Total Stock Market Etf	Mutual Funds and Exchange Traded Funds	115,193	109,313
	Virtus Allianzgi Art Int Tech Opp	Mutual Funds and Exchange Traded Funds	26,689	28,735
	Virtus Allianzgi Equity Conv Fd Co	Mutual Funds and Exchange Traded Funds	26,802	28,930
	Blackrock Esg Capital Allocation	Mutual Funds and Exchange Traded Funds	60,279	65,232
	Vanguard Long Term Bond Index ETF	Mutual Funds and Exchange Traded Funds	636,259	499,056
	Western Asset Inflation Linked	Mutual Funds and Exchange Traded Funds	162,467	143,628
		Total Investments	6,546,013	6,549,267

Denotes party-in-interest

ROCHESTER AREA CONSTRUCTION AND MATERIALS TEAMSTERS HEALTH AND WELFARE FUND SCHEDULE H, LINE 4J - SCHEDULE OF REPORTABLE TRANSACTIONS FOR THE YEAR ENDED JULY 31, 2022

EIN: 16-0962644 PLAN NUMBER: 501

Supplemental Schedule B

	(h)Current												
						(()Expense				Value of		
		(c)Purchase	1	(d)Selling	In	curred with	1	(g)Cost of	T	ransaction	(i)	Net Gain
(a) Identity of Party Involved	(b) Description of Asset		Price		Price	T	ransaction		Asset		Date	- 0	or (Loss)
BofA Securities Inc.	Level 1 Investments	\$	356,977		N/A	\$	497	\$	356,977	\$	356,977		N/A
BofA Securities Inc.	Level 1 Investments		N/A	\$	442,362	\$	761	\$	428,974	\$	442,362	\$	13,388
Cap Institutional Services Inc.	Level 1 Investments	\$	1,773,144		N/A	\$	115	S	1,773,144	\$	1,773,144		N/A
Cap Institutional Services Inc.	Level 1 Investments		N/A	\$	1,450,804	\$	241	\$	1,274,074	\$	1,450,804	\$	176,730
Mizuho Securities USA LLC	Level 1 Investments	\$	612,012		N/A	\$	462	\$	612,012	\$	612,012		N/A
Mizuho Securities USA LLC	Level 1 Investments		N/A	\$	273,582	\$	277	\$	274,429	\$	273,582	\$	(847)
National Financial Services	Level 1 Investments	\$	403,565		N/A	\$	314	\$	403,565	\$	403,565		N/A
National Financial Services	Level 1 Investments		N/A	\$	829,169	\$	572	\$	779,135			\$	50,034
Wedbush Morgan Securities, Inc.	Level 1 Investments	\$	110,297		N/A	s	277	\$	110,297	\$	110,297		N/A
Wedbush Morgan Securities, Inc.	Level 1 Investments		N/A	\$	436,054	\$	632	\$	326,739	\$	436,054	\$	109,315
US Bank Mmda Global Fund Services 4	Money Market Funds	\$	2,435,829		N/A	s	•	\$	2,435,829	\$	2,435,829		N/A
US Bank Mmda Global Fund Services 4	Money Market Funds		N/A	\$	500000000	5.395		\$	2,330,695	\$	2,330,695	\$	₽
First Am Govt Ob Fd Cl Y	Money Market Funds	\$	200,409		N/A	\$	=):	\$	200,409	S	200,409		N/A
First Am Govt Ob Fd Cl Y	Money Market Funds	-	N/A	\$	206,489	-		\$	206,489	\$	206,489	\$	-
Vanguard S&P 500 ETF	Level 1 Investments	S	590,213		N/A	S	11	\$	590,213	\$	590,213		N/A
Vanguard S&P 500 ETF	Level 1 Investments	٠	N/A	\$	188,630	3.5	4	\$	119,922		188,630	\$	68,708

See accompanying notes.

ROCHESTER AREA CONSTRUCTION AND MATERIALS TEAMSTERS HEALTH AND WELFARE FUND SCHEDULE H, LINE 4I - SCHEDULE OF ASSETS (ACQUIRED AND DISPOSED WITHIN YEAR) FOR THE YEAR ENDED JULY 31, 2022

EIN: 16-0962644 PLAN NUMBER: 501

		-	plemental hedule C	
(c) Description of Investment	(c) Cost of Acquisitions	(d) Proceeds Disposition		
Vanhanna Tech Edge 1 Sh & 1/2Wt	\$ 153,000	\$	154,070	

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HEALTH AND WELFARE FUND

SCHEDULE H, LINE 4I - SCHEDULE OF ASSETS (HELD AT END OF YEAR) July 31, 2022

EIN: 16-0962644 PLAN NUMBER: 501

Supplemental Schedule A

				 Current
(a)	(b) Identity of Issue	(c) Description of Investment	(d) Cost	Value
*	US Bank Mmda Global Fund Services	Money Market Funds	\$ 150,636	\$ 150,636
	Bannix Acquisition Corp Com	Common Stock	150,399	152,694
	Gigcapital 5 Inc	Common Stock	149,273	151,001
	McLaren Technology Acq Corp Class A		152,611	156,028
	Mountain Crest Acqusitn Crp IV Com	Common Stock	146,550	148,275
	Neuberger Berman Nest Generation	Common Stock	89,419	62,202
	Property Solutions Acquisition	Common Stock	138,134	136,743
	First Eagle Altr Ser 5.0% Preferred	Preferred Securities	116,250	110,670
	Gladstone Invt Corp 5.0% Preferred	Preferred Securities	140,625	133,313
	Oxford Lane Cap Ser 2024 6.75%		39,045	40,881
	Preferred	Preferred Securities		
	Phenixfin Corp 6.125% Preferred	Preferred Securities	23,450	23,557
	Priority Income Fund Ser H 6.0%		145,373	143,559
	Preferred	Preferred Securities		
	Terra Inc Fund 6 Ser 7.0% Preferred	Preferred Securities	137,940	138,750
	Ares Acquisition Corporation Com	Foreign Stock	146,700	148,050
	Tiga Acquisition Corp	Foreign Stock	156,002	158,928
	Vahanna Tech Edge Acqstn I Crp Class	Foreign Stock	151,623	153,383
	Aberdeen Emerging Markets Equity		o n sanna	,
	Income	Mutual Funds and Exchange Traded Funds	38,799	22,484
	Aberdeen Emerging Markets Equity Inco	Mutual Funds and Exchange Traded Funds	29,997	24,870
	Blackrock Global Energy & Res Tr	Mutual Funds and Exchange Traded Funds	19,048	18,322
	Blackrock Enhd Glb Div Trt	Mutual Funds and Exchange Traded Funds	28,918	38,265
	Blackrock Enhed Intl Div Trt	Mutual Funds and Exchange Traded Funds	21,418	20,830
	Blackrock Science And Technology	Mutual Funds and Exchange Traded Funds	37,770	27,491
	Blackrock Health Sci Tr II	Mutual Funds and Exchange Traded Funds	13,357	14,272
	Blackrock Science Technology Trust	Mutual Funds and Exchange Traded Funds	11,211	9,309
	Blackrock Innovation And Grw	Mutual Funds and Exchange Traded Funds	42,078	25,272
	Gabelli Divid & Income Tr	Mutual Funds and Exchange Traded Funds	53,290	75,418
	Invesco QQQ Trust Etf	Mutual Funds and Exchange Traded Funds	74,425	80,442
	Invesco S P 500 Equal Weight ETF	Mutual Funds and Exchange Traded Funds	44,797	47,398
	Ishares Msci Canada ETF	Mutual Funds and Exchange Traded Funds	44,268	55,790
	Ishares Msci Global Min Vol Etf	Mutual Funds and Exchange Traded Funds	54,351	54,695
	Ishares Msci Emerging Markets Etf	Mutual Funds and Exchange Traded Funds	27,657	25,735
	Ishares Msci Switzerland Etf	Mutual Funds and Exchange Traded Funds	20,442	21,310
	Ishares S&P Global Energy Etf	Mutual Funds and Exchange Traded Funds	19,146	18,669
	Ishares Russell 1000 ETF	Mutual Funds and Exchange Traded Funds	159,155	178,211
	Ishares Europe Etf	Mutual Funds and Exchange Traded Funds	50,280	52,570
	Ishares Msci Acwi Ex US Etf	Mutual Funds and Exchange Traded Funds	39,878	33,494
	Ishares Msci Acwi Etf	Mutual Funds and Exchange Traded Funds	45,964	40,419
	Ishares Msci China Etf	Mutual Funds and Exchange Traded Funds	29,761	27,826
	Ishares Msci Japan Etf	Mutual Funds and Exchange Traded Funds	65,302	62,046

^{*} Denotes party-in-interest

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HEALTH AND WELFARE FUND

SCHEDULE H, LINE 4I - SCHEDULE OF ASSETS (HELD AT END OF YEAR) July 31, 2022

EIN: 16-0962644 PLAN NUMBER: 501

Supplemental Schedule A

(a) (b) Identity of Issue	(a) Department of Investment	(A) C4	(e) Current
A STATE OF THE PROPERTY OF THE	(c) Description of Investment	(d) Cost	Value
Ishares Msci Intl Quality Factor Etf	Mutual Funds and Exchange Traded Funds	11,822	11,196
Ishares Msci United Kingdom Etf	Mutual Funds and Exchange Traded Funds	22,578	21,946
Japan Smaller Capitalization Fd Inc	Mutual Funds and Exchange Traded Funds	22,392	15,510
Mainstay Cbre Glob Infra Megatrends	Mutual Funds and Exchange Traded Funds	45,964	46,135
M S D W India Investment Fund	Mutual Funds and Exchange Traded Funds	20,791	18,977
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Vanguard Long Term Bond Index ETF	Mutual Funds and Exchange Traded Funds	636,259	499,056
Western Asset Inflation Linked	Mutual Funds and Exchange Traded Funds	162,467	143,628
	Total Investments	6,546,013	6,549,267

^{*} Denotes party-in-interest

ROCHESTER AREA CONSTRUCTION AND MATERIALS TEAMSTERS HEALTH AND WELFARE FUND SCHEDULE H, LINE 4J - SCHEDULE OF REPORTABLE TRANSACTIONS FOR THE YEAR ENDED JULY 31, 2022

EIN: 16-0962644 PLAN NUMBER: 501

Supplemental Schedule B

						(h)Current								
					(f)Expense				Value of					
		((c)Purchase		(d)Selling		Incurred with		(g)Cost of		Transaction		(i)Net Gain	
(a) Identity of Party Involved	(b) Description of Asset	Price			Price		Transaction		Asset		Date		or (Loss)	
BofA Securities Inc.	Level 1 Investments	\$	356,977		N/A	\$	497	\$	356,977	\$	356,977		N/A	
BofA Securities Inc.	Level 1 Investments		N/A	\$	442,362	\$	761	\$	428,974	\$	442,362	\$	13,388	
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Cap Institutional Services Inc.	Level 1 Investments		N/A	\$	1,450,804	\$	241	\$	1,274,074	\$	1,450,804	\$	176,730	
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Mizuho Securities USA LLC	Level 1 Investments		N/A	\$	273,582	\$	277	\$	274,429		273,582	\$	(847)	
National Financial Services	Level 1 Investments	S	403,565		N/A	\$	314	\$	403,565	S	403,565		N/A	
National Financial Services	Level 1 Investments		N/A	\$	829,169	15150	572	\$	779,135			\$	50,034	
Wedbush Morgan Securities, Inc.	Level 1 Investments	S	110,297		N/A	S	277	\$	110,297	S	110,297		N/A	
Wedbush Morgan Securities, Inc.	Level 1 Investments	1,000	N/A	\$	436,054		632	\$	5		436,054	\$	109,315	
US Bank Mmda Global Fund Services 4	Money Market Funds	\$	2,435,829		N/A	2		\$	2,435,829	s	2,435,829		N/A	
US Bank Mmda Global Fund Services 4	Money Market Funds		N/A	\$	2,330,695		7	\$	2,330,695	\$	2,330,695	\$	-	
First Am Govt Ob Fd Cl Y	Manay Market Funda	s	200 400		NIIA	e		•	200 400	•	200 400		27/4	
First Am Govt Ob Fd Cl Y	Money Market Funds Money Market Funds	4	200,409 N/A	S	N/A 206,489		-	S S	200,409 206,489		200,409	c	N/A	
I not the dore of the city	money market runds		IN/A	J	200,409	J	B)	T)	200,409	Þ	206,489	Þ	•	
Vanguard S&P 500 ETF	Level 1 Investments	\$	590,213	1000	N/A		11	\$	590,213	\$	590,213		N/A	
Vanguard S&P 500 ETF	Level 1 Investments		N/A	\$	188,630	\$	4	\$	119,922	\$	188,630	S	68,708	

See accompanying notes.